

Winter 1981

## Jefferson Alumni Bulletin – Volume XXX, Number 2, Winter 1981

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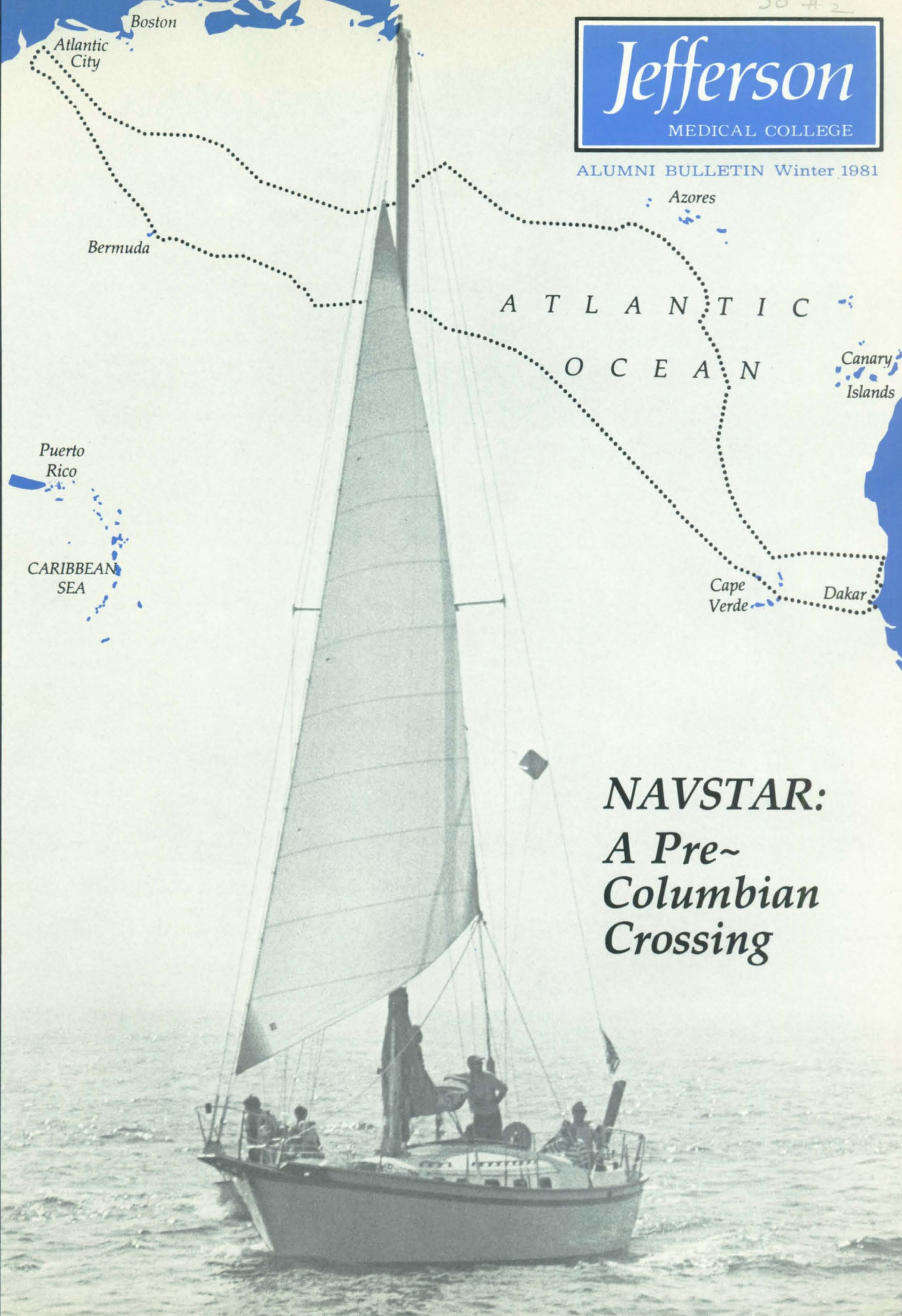
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# Jefferson

MEDICAL COLLEGE

ALUMNI BULLETIN Winter 1981



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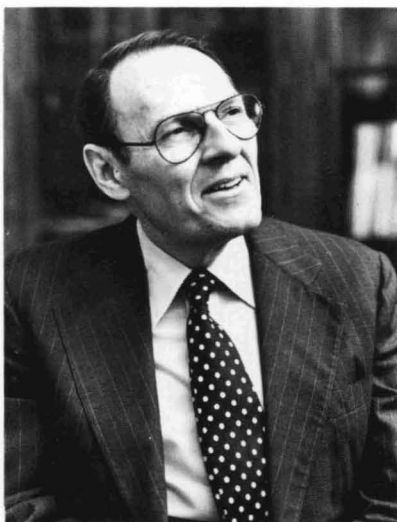
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## NAVSTAR: A Pre~ Columbian Crossing

## The State of the College

by William F. Kellow, M.D.

Dean and Vice President



*Dean Kellow*

The Council on Medical Education of the American Medical Association published a document this year entitled "Future Directions for Medical Education" and it has prompted considerable discussion about the many issues facing medical education in this country currently. While disagreements have been expressed about several positions which the Council has taken and particularly about a recommendation that the first postgraduate year be a general one, there has probably been more agreement than otherwise about most of the 25 recommendations in this report.

The release of a national report of this magnitude presents an occasion for us at Jefferson to look at those issues which concern undergraduate medical education and compare the recommendations in this report with the conclu-

sions which we have reached independently as we have deliberated these same matters in recent years. The report, for example, refers to the need for a structured clinical education in the third and fourth years of medical school and warns that an unstructured fourth year can deny a student the basic skills necessary for the total care of a patient in the first postdoctoral year. Those were considerations here in 1972 and 1973 when the third year was designed to be a basic clerkship year in six disciplines and the fourth year was designed to be a more balanced experience than had occurred with the curriculum of 1967. As a result, while the final year now offers elective opportunities, the electives must be taken within the structure of one of the broad disciplines and with some order and sequence.

The education of physicians prior to medical school is a prominent topic of this report, and it includes a recommendation that the college years provide a broad cultural education in the liberal arts and social sciences as well as in the traditional sciences which are requisite for medicine. Just a year ago, the admissions committee received a grant from the Macy Foundation to explore such matters with a group of colleges which our students commonly attend before coming to Jefferson. Several meetings have been held this year between members of our admissions committee and people from the faculties of these colleges to pursue these very topics. Representatives of the Macy Foundation staff have also attended, and they are pleased with the progress of these sessions and indicate that the grant has been given high priority for renewal.

The criteria for assessing an applicant's personal qualities which we use in the admissions process continue to concern us all, and the report on "Future Directions" emphasizes the need to seek better ways of identifying the moral and behavioral characteristics of applicants. While our admissions committee has developed ways of giving greater emphasis to such factors in recent years, no one would claim confidence in this aspect of the evaluation of applicants. This is one aspect of the admissions process which does need further thought, and it will not be easy to evolve fail-safe criteria for judging personal attributes as our previous efforts have shown.





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## Diverse Specialties Harmonize

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Jefferson's Spinal Cord Injury Center provides a comprehensive system of medical and rehabilitation care.

### Editor

Nancy S. Groseclose

### Assistant Editor

Ella C. Remington

## The Navstar: a Pre Columbian Crossing

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Edgar T. Gibson '42 served as first mate on a transatlantic voyage made without the aid of modern navigational equipment.

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## President Cleveland's Lesion: New Evidence Uncovered

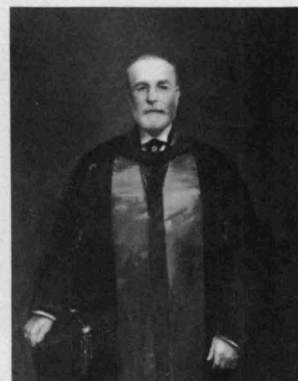
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W. W. Keen, M.D., pictured at left, Jefferson's first Samuel D. Gross Professor of Surgery, was Chief Surgeon during the excision of President Cleveland's tumor. New evidence concerning the diagnosis of the tumor is related by John J. Brooks, M.D. and Horatio T. Enterline, M.D.

## Class Notes

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Three alumni in the classes of 1947, 1965 and 1978 are featured.



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Diverse  
Specialties  
Harmonize  
*Spinal Cord Injury  
Center at Jefferson  
takes a  
team approach to care*

by Ella C. Remington

The conductor of an orchestra must be able to direct the sounds of many diverse instruments into one harmonious alliance. Unlike the conductor, whose synchronization skills are in demand only during rehearsals and concerts, the direction of the Regional Spinal Cord Injury Center of the Delaware Valley requires intricate coordination day in and day out. The Center at Thomas Jefferson University Hospital, in affiliation with Magee Memorial Rehabilitation Center (JAB Fall 1977) and Philadelphia Elwyn Institutes, is one of 14 Regional Model Spinal Cord Injury Centers in the United States. John F. Ditunno, Jr., M.D., Chairman of the Jefferson Medical College Department of Rehabilitation Medicine, described by those he works with as the dynamic organizational force behind the Center, is the Project Director. Dr. Ditunno is assisted in his directional role by Jewell L. Osterholm, M.D. and Jerome M. Cotler, M.D. '52, Co-assistant Directors for Acute Care, William E. Staas, Jr., M.D. '62 and Albert Bussone, Co-assistant Directors for Ongoing Care, and Lorraine E. Buchanan, R.N., M.S.N., Project Coordinator.

Time and proper care will heal a wound or mend a broken limb, but a person whose spinal cord has been severely injured faces permanent physical disability. Prior to World War II, those with spinal cord injuries had an approximate life expectancy of less than three years. Confined to their beds, those who survived the initial injury could be expected to fall prey to complications arising from the urinary tract, pulmonary complications, or decubitus ulcer infections. Today, however, patients can live almost a normal life span, and through rehabilitation, are able to work towards maximum function within the limits of their disability.

Spinal cord lesions create enormous medical, economic and social demands. Because spinal cord injury affects most

bodily functions, it requires treatment by a variety of specialists. Traditional care has been very fragmented as the neurosurgeon or orthopaedic surgeon tends to be the primary physician until the time comes when it is necessary to consult another specialist. Medical care costs are greater than for other types of neurologic conditions. Statistically, about 80% of all spinal cord injured patients are male, and about 80% are between the ages of 15 and 30. These young patients have just started their adult lives and just begun their careers. About 50% are married. Most have either a young family or are still living with their parents. Spinal cord injuries usually happen to athletically inclined individuals, many of whom earn their living using their hands and doing physical work, so the injuries frequently have an extremely disruptive impact on patients' lifestyles.

A spinal cord injury rehabilitation model concept proposed to Congress and the rehabilitation field by the Rehabilitation Services Administration, Department of Health, Education and Welfare (now Department of Education), in the early 1970's and authorized by Congressional legislation in 1973 makes it possible for spinal cord injured patients to receive the most up-to-date, thorough medical care, rehabilitation and vocational training available. The model systems' concept is designed to reduce the development of needless medical complications and related expenses, to gain new knowledge through research which is readily accessible to all members of the system, and to provide follow-up care for spinal cord injured patients which enables them to function to their capacity in society.

Rapid case finding and referral, early rehabilitation coordinated by a sophisticated multidisciplinary team, timely reporting to a national data research center, the involvement of community agencies and services and a long term program to ensure gains are maintained, are components essential to achieving the model systems' aims. With these components in mind, the model systems' concept provides for the establishment of regional centers in geographic areas of natural patient flow which furnish

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*Mrs. Remington, who joined the JAB bulletin staff in October, is a graduate of Mississippi University for Women and received a master of arts in communication from Glassboro State College in New Jersey.*

multi-faceted rehabilitation care from the point of injury, including emergency treatment and transportation, throughout the patients' lives. A National Data Research Center collects and collates information on spinal cord patients from all the regional centers.

Pennsylvania and the Delaware Valley did not have a comprehensive system for the rehabilitation of spinal cord injured patients prior to the designation of the Regional Spinal Cord Injury Center of the Delaware Valley. Victims were taken to small hospitals or to institutions which frequently lacked the facilities and personnel to handle their complex needs. Although some competent centers existed for the acute care

tem are a procedure for emergency care and early referral to the Center, coordination of acute medical and surgical care, rehabilitation management beginning at the onset of acute care, vocational evaluation, training and placement, and a plan for lifetime follow-up care which covers medical, social, psychological and vocational adjustment. He explains, "My responsibility is to establish this system and to continue to work toward refining the system, aware of the fact that none of the 14 centers has all elements of this to the highest degree."

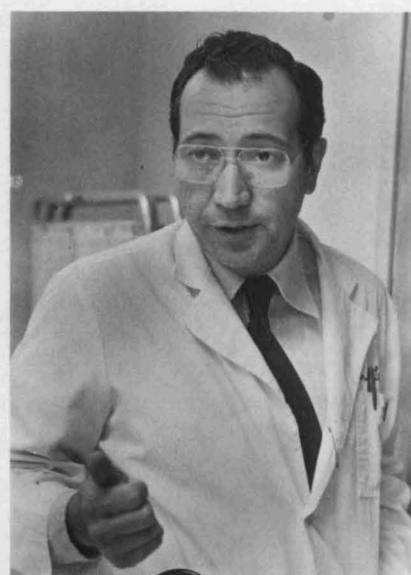
Pulling together the divergent disciplines of neurosurgery, orthopaedic surgery, rehabilitation medicine, general surgery, internal medicine, urology,

the time the patients enter the emergency room through their surgical and medical stabilization. Jefferson has a unique multidisciplinary spinal cord injury team of physicians and medical professionals which meets patients upon their arrival in the emergency room. "We make a determination in that setting of the nature of the person's injury and the associated complications and problems," Dr. Ditunno explains.

Compounding the spinal cord injury in which there may be paralysis, there is the possibility of associated fractures, head injuries, or injuries to other structures such as the abdomen, thorax or lungs. After the team has determined the assorted medical and surgical prob-



*"The first line  
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in the facility  
and their stabilization,"  
Dr. Ditunno.*



stage, integrated long term follow-up care was not readily available. Recognizing the need for an all encompassing system of managing spinal cord injured patients, Jefferson and Magee started working cooperatively toward this goal in July 1976. As spinal cord injured patients have a tremendous need for vocational evaluation and training, Jefferson affiliated with Elwyn Institutes, which had expertise in this area, early in 1978. The three institutions' initial cooperation set the stage for the Center's official designation in October 1978.

Dr. Ditunno, as Project Director, is concerned with developing a model system on the basis of the criteria the government has defined. According to Dr. Ditunno, the major elements of a model sys-

tem are a procedure for emergency care and early referral to the Center, coordination of acute medical and surgical care, rehabilitation management beginning at the onset of acute care, vocational evaluation, training and placement, and a plan for lifetime follow-up care which covers medical, social, psychological and vocational adjustment. He explains, "My responsibility is to establish this system and to continue to work toward refining the system, aware of the fact that none of the 14 centers has all elements of this to the highest degree."

Pulling together the divergent disciplines of neurosurgery, orthopaedic surgery, rehabilitation medicine, general surgery, internal medicine, urology,

lems, they triage what is best for the patient. Each team member has a job description. Neurosurgery's primary responsibility is to assess the patient neurologically looking at both spinal and head injuries. The rehabilitation physician confirms the neurological examination and records it. The orthopaedic surgeon determines the degree of instability of the spine and any associated fractures and recommends the immobilization procedure.

Together with the neurological condition, the rehabilitation physician also pays attention to other systems such as the pulmonary and urinary tract. Dr. Ditunno reveals, "We start a number of things even within 24 hours that I regard as part of the rehabilitation process. The



*"The primary purpose  
of the system is to  
problem identify  
and then problem solve  
with the patient,"  
Dr. Staas.*



first line of rehabilitation is the proper triage of the patients in the facility and their stabilization. The best rehabilitation is preventing further neurological deficit." Rehabilitation physicians make rounds daily. Bowel and bladder training is started as soon as possible. The rehabilitation physician together with other physicians makes sure that problems which prolong hospitalization and increase the risk of death such as decubitus ulcers, internal infections or pulmonary embolisms are being prevented. Patients are also seen daily by physical therapists, occupational therapists, and, if required, speech therapists. The therapists' early bond with the patients expedites the transition back to a productive life style.

"I frequently on admission will meet with the family and remain the physician in contact through the entire acute phase, and then, within the first week, I will sit down for an hour for a conference in which I will discuss with the family precisely what has happened. Demonstrating with a model of the spine, I explain the nature of the fracture, if there is a fracture, and the nature of injury to the spinal cord. If the injury is permanent and complete, I inform the family at that point. I discuss with them the possible associated complications of spinal cord injury, the possibility of urinary tract infections, deep vein thrombosis, skin breakdown. I also outline for them what I feel the prognosis of the patient will be. What the

patient should be able to achieve short term and long term. I describe the various stages within a time frame of where the patient will be in the hospital," says Dr. Ditunno.

A social worker is also assigned to the case of a spinal cord injured patient during the acute phase. The social worker is in contact with the family, sets up meetings and acts as Dr. Ditunno's liaison to the family. "We begin to prepare the family for the dislocations that are going to occur by nature of somebody very loved and very important to the family being out of action for months in the hospital. We advise the family how to pursue the various physical resources for the ultimate bringing the person home, the kind of equipment needs they will have, and the psychosocial aspects that they must deal with," Dr. Ditunno explains.

Dr. Ditunno's role further involves prescribing physical and occupational therapy, being Chairman of a weekly conference on definitive surgery which discusses and determines patients' surgical requirements, and supervising and overlooking all areas of care.

Working closely with Dr. Ditunno is Magee's President and Medical Director, William E. Staas, Jr., M.D. Dr. Staas' positive attitude and magnetic personality make it easy to understand his ability to inspire spinal cord injured patients to tackle the extremely taxing and laborious task of physical and vocational rehabilitation. His enthusiasm is rooted in a genuine

interest in working with spinal cord injured patients which unfolded during his residency at Jefferson. He was strongly influenced by physical medicine and rehabilitation faculty members, in particular John W. Goldschmidt, M.D., '54, who was then the Director of Physical Medicine and Rehabilitation.

Dr. Staas, who is a Clinical Professor at Jefferson, explains that although the Center has different physical environments, it "is conceptualized as a single staff," and there is close cooperation between the staffs of Jefferson and Magee. "We've had rotation of staff, exchange if you will, of therapists, social workers, and so forth. We're even looking at the possibility of rotating medical staff between the two environments," says Dr. Staas.

Dr. Staas sees spinal cord injured patients as the most demanding and challenging within the rehabilitation sphere and thus, an excellent teaching model for students. In fact, the Department of Family Medicine at Jefferson requires residents to do a rotation through the Department of Rehabilitation Medicine. During this rotation, the family practitioner becomes familiar with the complex needs of spinal cord injured patients and the resources available through the Center. Since patients' lifetime care needs can be met most effectively by an informed family physician, Dr. Staas believes cooperation between the Center and family physicians is exceedingly important.





*"As you look around the country at other centers, I think the growth of our group has been exceptional,"*  
Dr. Cotler.

After discharge from the Center, patients are seen at approximately one month, then three months, then six months, then 12 months, and then every 12 months thereafter. Dr. Staas predicts that all phases of care at the Center will continue to refine and evolve, particularly the follow-up phase which will involve more and more patients as the years pass. "The follow-up system is geared to provide lifetime service to the patient. Patients are instructed to contact us if they have a problem or question, and we refer them to Jefferson or Magee depending on the nature of the problem. The primary purpose of the system is to problem identify and then problem solve with the patient," he states.

Dr. Staas' work involves reaching out and striving to work with the patient to achieve goals, and he views his "willingness to learn and accept we don't have everything" as attitudes which are valuable to him in this role. He notes that he would like other physicians to know that the Center welcomes inquiries regarding its resources and other specific information. (For those interested in more information, the Center's information number is (215) 928-6579, and letters can be addressed to the Spinal Cord Injury Center of the Delaware Valley, Thomas Jefferson University Hospital, 11th and Chestnut Sts., Philadelphia, Pa. 19107.)

As an orthopaedic surgeon, Jerome M. Cotler, M.D., Clinical Professor at Jefferson, is primarily concerned with

the skeletal components and how they function in association with the neural elements. When asked to discuss the role of the orthopaedic surgeon in the Center, Dr. Cotler explains that his specialty relates to bones, muscles and ligaments and their protective requirements regarding the neural elements, peripheral nerves and spinal cord. "Our responsibility is to determine which injury is stable from a bony protective perspective and which is unstable." Orthopaedic surgery attempts to ascertain which of the patient's functional capabilities is being compromised by the injury." Compromised ability means there may be primary damage to the spinal cord or peripheral nerves or the threat of potential damage to these several elements occurring as a result of some act the patient would perform during normal physiological activities. Dr. Cotler notes the difficulty in assessing individual patients. "We don't always know what someone's normal activity level is going to be and certainly not the potential for accident."

Dr. Cotler's initial decision to become an orthopaedic surgeon began while he was an intern at Jefferson. At that time doctors were not required to make early career choices as is currently necessary, and rotating internships were the norm rather than the current categorical Post Graduate Year one. Dr. Cotler relates, "As an intern assigned to orthopaedic surgery, I first ex-

perienced one-on-one contact with Dr. Anthony F. DePalma '29 who was Chairman of the department. Dr. DePalma is a very mesmerizing, stimulating type of person who demonstrated tremendous capabilities of attracting and stimulating young people." Dr. Cotler was also influenced in his career choice by Hal E. Snedden, M.D. '50, Clinical Associate Professor and now Chief at Bryn Mawr Hospital, who administratively was the more senior orthopaedic resident.

Dr. Cotler describes himself as a compulsive, hard-working man who likes to see the results of his labor which in orthopaedic surgery are easily demonstrated through patient functional return and correlated with x-ray documentation. He also has the intense concentration required to perform delicate surgery. "I can turn the outside world off for the time required and direct my attentions to the surgical problems at hand. This is most important for a surgeon because the patient's needs are usually best served with a minimal number of well performed surgical exposures," he explains. Familiar with the care patients receive outside organized centers, Dr. Cotler stresses the importance of early referral following spinal injury. "On occasion, the initial treating physicians are not as familiar with current innovations in the total care package for the spinally injured patient, and as a result, in all good conscience, have

embarked on dated methods of management.

Human nature being as it is, the initial bond evolved between physician and patient at ground zero may not be transferred upon referral. It is more difficult to be completely knowledgeable of foregone events when a problem arises in midstream and subtleties and innuendos of prior treating physicians' hopes or patient's expectations of such catastrophic injuries may be missed. Patients with such severe and disabling injuries, as well as their families, very often harbor great concerns and even resentment relating to past care received at various points along the long path.

Hopefully, these attitudes can be adjusted by the lifetime of care concept." After examining and assessing his patients, Dr. Cotler attempts to inform them of the spectrum of care available with its associated gains, as well as downsides risks, hoping to aid them in the decision making process.

Dr. Cotler believes the Center shows broad vision and is a real tribute to the institutions and individuals involved. He notes, "as you look around the country at other spinal cord injury centers, I think the growth of our group has been exceptional. It's just been far, far better and exceeded most people's expectations." Dr. Cotler believes it is important for physicians to be receptive to their support areas. "I think that if phy-

sicians will recognize the good that a team approach can offer to society in many of its illnesses and infirmities, society will profit from it. No single physician or discipline can possibly offer full service medicine in 1980."

The Spinal Cord Injury Library-Learning Resource Center is located on the ninth floor of the New Hospital on Jefferson's campus. Developed over a ten month period with the assistance of Ms. Ina Brown, M.L.S., the library, which became operational on March 1, 1980, contains many resources not readily available in affiliate libraries. It has a collection of approximately 650 journal reprints, a core collection of text books and professional journals and various audio-visual programs. The library technician, Andrew M. Coleman, is an efficient, versatile young man with a background in film and audio-visual aides. In addition to his duties as librarian, Mr. Coleman functions as the Center's photographer and prepares and organizes multi-color slide presentations as required. Audio-visual programs are used for patient education, staff inservice training and continuing education. The library has been utilized by staff physicians, representatives of every allied health discipline in the Center, as well as by the private insurance industry.

The Project Coordinator, Lorraine E. Buchanan, R.N., M.S.N. is a vibrant 29 year old exuding enthusiasm for her

work. Ms. Buchanan is a clinician at heart, primarily interested in patient care, though her job as Project Coordinator is heavily administrative. "Though I'm now working in an administrative capacity, I feel my efforts have helped to improve the care of patients. I look at my work as a tremendous challenge both personally and professionally and get satisfaction from being part of a dynamic and worthwhile program," she says. The program's dynamism is certainly evident in Ms. Buchanan whose dedication and concern for her patients is a driving force in her life. "I've learned to adjust my way of judging progress and quality of life. The Director of the National Data Research Center, Dr. John Young, wrote something to the effect that one of the amazing things about working with spinal cord patients is that you meet heroes every day, and these are common, ordinary heroes. You can't believe what the human spirit can really deal with. Spinal cord injury disrupts so many different body systems, and we see people deal with that and persevere through it. Obviously they don't all have happy lives, but they deal with their lives and many are happy. Many go back to a job or find a new job or start a new career, and really become part of society again," remarks Ms. Buchanan.

Readjusting to society is probably more traumatic emotionally than physically for a spinal cord injured person be-



*"I look at my work as a tremendous challenge... and get satisfaction from being part of a dynamic and worthwhile program,"*  
Ms. Buchanan.



cause of society's tacit proscription of disability. Ms. Buchanan relates, "Society teaches us not to look at or pay attention to disabled people. It's as if there's something wrong if you're in a wheel chair. We have all kinds of architectural barriers and social barriers. When it happens to you, all those things say there's something wrong with you, wrong, not physically, but as if you've done something wrong."

Ms. Buchanan illustrates some of the obstacles facing spinal cord injured patients in the community: "If a patient goes into the community and he doesn't have a family doctor or the family doctor he's always gone to doesn't make house calls or has an office inaccessible to a wheel chair, he may not have any health care, which is why we have established a follow-up clinic. We're committed to providing lifetime care. We had one young man whom we tried for six months to get to go see a family physician. When he finally did make an appointment, there was a spiral staircase up to the doctor's office, and that turned the patient off entirely. Public transportation is impossible. Unless the patient has special transportation, which is very expensive, he has trouble even getting back to us for follow-up. Transportation is the number one problem in getting patients back to us for follow-up. How do we get them here? Magee

has one van which we sometimes use, but it's overcommitted. Housing is another problem. The average house in Philadelphia is a row house with 13 steps to the second floor, and there is virtually no way to ramp the way into the house because it is so close to the street. So the patient tends to be a captive in his own home.

Added to the external societal conflicts, some patients may also be dealing with an internal guilt because they were not totally the innocent party to their injuries. Automobile accidents are the number one cause of spinal cord injuries. Some of these are related to drug or alcohol use. Even a diving accident may make a patient feel his lack of sound judgement caused his injuries.

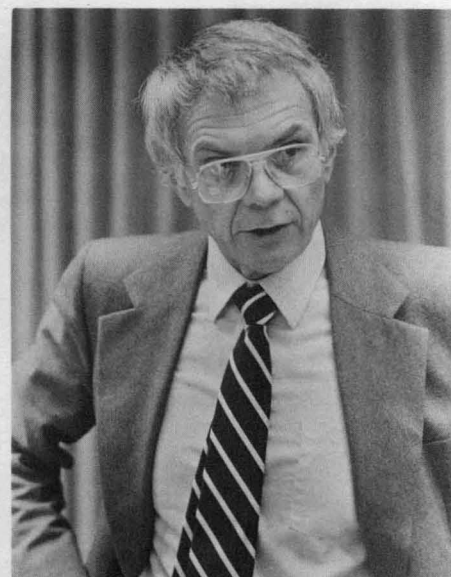
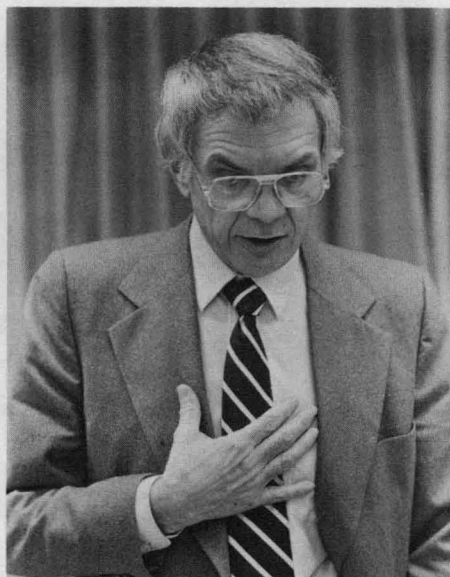
Working closely with the patients' family physicians from the very beginning is one way the Center attempts to mitigate problems. Communicating the Center's capabilities and objectives to the community is another. As part of her role as Project Coordinator, Ms. Buchanan sends out information and speaks to interested groups about the Center. She has so far focused on emergency room nurses and physicians and has reached representatives of 75 hospital emergency rooms.

Proper handling at the emergency stage has been worked out in cooperation with the Philadelphia Fire Depart-

ment Rescue Service Paramedics. Dr. Ditunno teaches the Central Nervous System Module of the paramedic training program, and the paramedics use the facilities in the Health Science building at Jefferson for education. The paramedics' re-certification program now includes a tour of the Center and an explanation of the anatomy and physiology of spinal cord injury. Moreover, a protocol has been developed which enables paramedics to proceed directly to the Center bypassing the nearest hospital with medical approval if they suspect a spinal cord injury; thus, rehabilitation can commence without delay following stabilization.

Ms. Buchanan emphasizes that it is important for people to realize that there is a great deal that can be done for spinal cord injured patients. She remarks, "A C-4 quad in a motorized wheel chair can still be a father to his children. He can still hold a job; it is hard to get him one because of the way society is, but he can go out to work. With support and care, he can live, love, laugh and be happy. It's an adjustment, but it's not the end of the road." In conclusion, Ms. Buchanan positively proclaims, "I'm the eternal optimist. We got a man on the moon in ten years. If we got everyone focused on spinal cord injury, I believe that we could solve that too!"

*"The Center is dedicated to providing comprehensive medical, surgical and rehabilitative care to victims of spinal cord trauma,"*  
Dr. Osterholm.





# THE NAVSTAR:

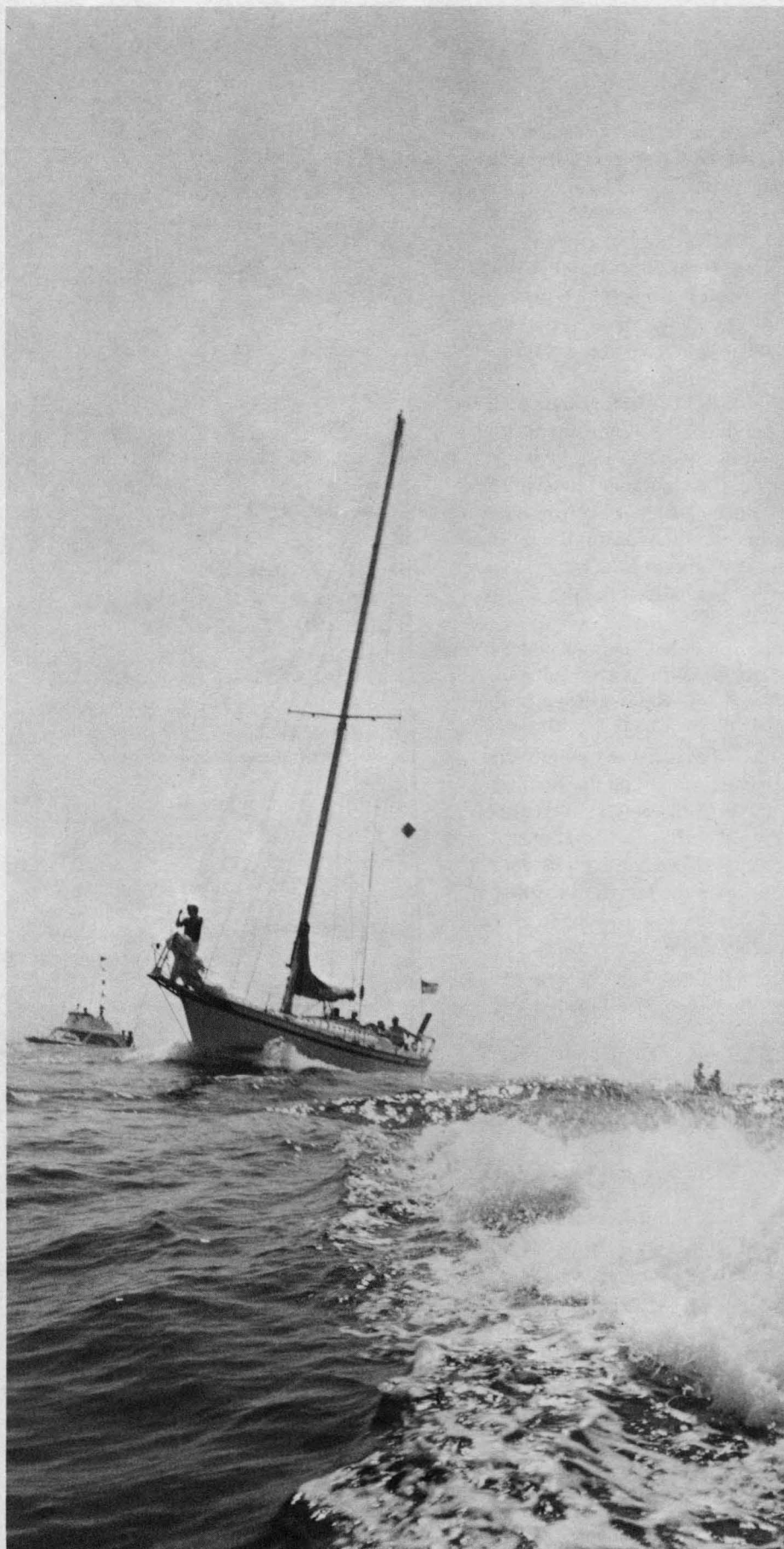
## A PreColumbian Crossing

by Linda A. Rabben



B. Vartan Bogelian

*A flotilla brings the Navstar to the Atlantic City coast following a three month ocean crossing without use of navigational instruments.*



The objective of the *Navstar's* transatlantic voyage was "to determine if information taken from the sky and sea with the unaided eye is sufficient to make reasonably accurate landfalls after long-distance journeys." In other words: take one 39-foot sailboat, put four men in it, lock up their navigational instruments and see if they can sail from Atlantic City, New Jersey, to Dakar, Senegal, and back. The reason for this feat was not only to see if it could be done, though a Coast Guard officer commented, "Just to make an Atlantic crossing in a vessel that size is an accomplishment. To do what they're proposing is fantastic."

What the four men wanted to prove was that preColumbian navigators could have traversed oceans without even the relatively simple tools that Columbus used. They wanted to show that shipwrecked sailors could rescue themselves if they watched seawater color, wind direction, wave direction, stars, sun, seaweed, animals and birds, much as Noah knew he was near land because he sighted a single dove. They also wanted to test the ARGOS satellite tracking system, which monitored their course to Africa and back. They would collect sargassum and ocean-borne tar for a pollution study by a Harvard professor. And, finally, they would test themselves as individuals and as team members against ideals of endurance and coordination on the troublesome Atlantic.

Among the four was a Jefferson alumnus, Edgar T. Gibson, '42, an unassuming man who used to be Chief of Surgery at West Jersey Hospital before retiring to devote time to interests like sailing, skiing and woodworking. Gibson was the first mate, assistant navigator and ship's doctor. The last task he took rather lightly. "I have made my first real contribution to medicine," he noted in his log. "I have modestly referred to it as the Gibson Syndrome, or technically the dry mouth syndrome. The etiology of it is fright or extreme anxiety. It comes from trying to swallow your heart that has climbed up into your mouth until finally there is no more room for saliva..." This comment he made in the middle of a four-day



## The Homecoming

The head waves were running high last July as we moved out to sea off Atlantic City to welcome home the *Navstar*. On board was Dr. Edgar Gibson '42, with three others, back from a six week voyage to and from Dakar without use of any navigational instruments. A flotilla of some 15 boats was on its way to commemorate this scientifically important voyage.

The staff of JAB learned of the expedition from front page stories in the local media. Contacts were made with Mrs. Gibson at her home in Newagen, Maine, and the public relations director for Atlantic City. Assured that we could obtain space on one of the Coast Guard cutters, three of us set off from Philadelphia the morning of the 18th.

When we arrived at the Frank S. Farley Marina a little before nine o'clock the dock was empty. Information about the pending arrival of the *Navstar* was non-existent. Worried that our early expedition was fruitless we wandered the Marina looking for help. At pier seven the Captain of the Three G's, Jim Gillian, explained that in addition to the Coast Guard cutters a fleet of 15 or 20 cabin cruisers, moored at the marina, would make up the flotilla. Sure .. he would take us with him. By this time members of the families were arriving but they seemed to be outnumbered by members of the press. It was to be a media extravaganza.

About 10:30 a.m. the flotilla took off. After a run of half an hour under gloriously sunny skies, we came in sight of the *Navstar*, with its crew on deck waving and shouting through megaphones. Noisily all of the skippers of the flag bedecked flotilla sounded their horns.

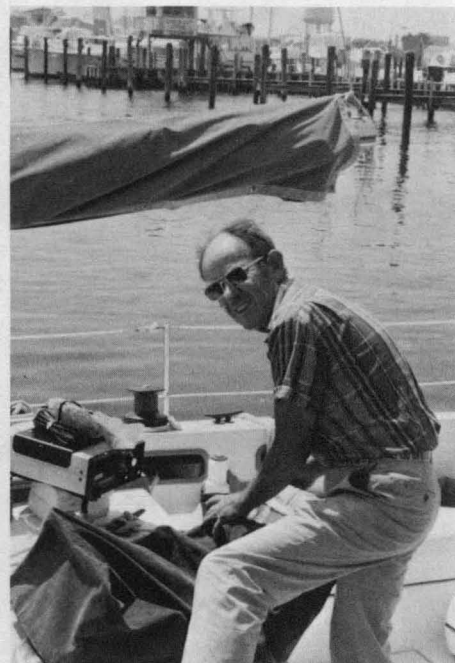
Finally the Coast Guard cutters carrying the wives came in to view. The most important members of the small fleet arrived last and on the smallest vessels. We felt guilty to be on the Three G's with both comfort and coffee. As the two "stars" of the flotilla drew together wives and husbands had an opportunity to greet each other. Beside the big cruisers the cutters look very small indeed. Mrs. Gibson had a precarious space on the bough of the first cutter. About ten of the big boats approached the *Navstar* and began circling so that the press people could film her from every angle. The cruisers wheeled across the wake of one another making footing difficult. Captains of the flotilla vied to demonstrate their seamanship, barely avoiding one another.

On the Three G's the camera man for Philadelphia's channel 6 was everywhere balancing his heavy movie equipment on his shoulders. Finally the skipper asked if we were ready to return to shore to await the *Navstar*'s triumphant arrival.

The journey back was fast and easy with none of the earlier head waves. When we reached the Marina a crowd was waiting, a band was playing and the sun was at high noon. On the dock the press was omnipresent, looking blasé and world weary. The crowd's excitement, however, became contagious as the *Navstar* came into view. Everyone cheered.

When the crew docked, Mrs. Gibson was left alone as the press attacked Professor Marvin Creamer, the *Navstar*'s Captain. Mrs. Gibson quietly slipped on board and gave her husband the welcome he deserved as first mate. Then Dr. Gibson helped a Coast Guard officer unseal the bag that held the navigational instruments. It was the first time they had been unpacked since the *Navstar* set sail for Africa in April.

Finally the band stopped playing, the interviews came to an end, the crowd faded away. The *Navstar* was going into dry dock, this adventure completed. N.G., L.R.



*Edgar T. Gibson '42, first mate of the Navstar opens the navigational instruments which were sealed throughout the entire voyage*



*The media seen in the cabin cruiser behind the Navstar made the homecoming an extravaganza. Papers and TV stations from up and down the east coast were represented.*

Gregg Kohl



gale with 40-knot winds and 25-foot seas. Without radios, the crew never knew how long such storms might last, or how much worse they might become. Nor, without navigational aids, could they tell how far off course they were being blown. They could only try to keep a straight course.

Dr. Gibson, a sailor with 20 years' experience, had some idea of what he was getting into when he signed on the *Navstar*. He had already sailed along the East Coast and from his home in Maine to Bermuda and back. His skipper, Marvin Creamer, is also an experienced sailor and retired geography professor from Glassboro, New Jersey, who has taught navigation. The voyage was Creamer's idea. It was he who provided the boat, the supplies (some of which he obtained from various sponsors) and the navigational expertise to make the trip feasible. The boat, a new fiberglass cutter, was ready for sailing only two weeks before the voyage began. Food consisted mainly of canned goods from sponsoring companies, who also provided some clothing and other essentials such as life preservers. The other crew members were Gary Doyle, a boatbuilder; William Nichols, a student who filmed the eastbound part of the trip; and Kenneth Helfant, a psychologist who joined the crew in Dakar to make his first ocean crossing. Although Creamer had sailed home from England in 1978 without using instruments, a round trip to Dakar was far more ambitious than anything he had yet attempted.

On April 11, 1980, the *Navstar* set sail from Atlantic City. Although navigational instruments were on-board, they were sealed in a bag that was only to be opened in case of dire emergency or at the end of the voyage. No crew member had a wristwatch, radio, direction finder or compass. Instead, they used their own bodies as sextants, measuring the positions of stars with outstretched arms, and watched for all sorts of natural signs to guide them. They looked for a glow in the sky during daytime storms to find where the sun was; took star sightings whenever possible; watched waves, whose direction changed more slowly than the wind's;

put up and took down sails; prepared meals; washed dishes; did laundry; made repairs on the boat; stood watch; ate and slept.

A yacht, someone said, is "a small world unto itself." For the crew of the *Navstar*, busy activity alternated with boredom and sometimes with fear, when a storm pounded the boat and made the rigging shake. During a storm they had to work together well. Inevitably, there was no escape from the others. Yet, Gibson says, they got along amazingly well, learning how to keep out of one another's way by retreating into a book or their own thoughts. They had no arguments. Porpoises became special friends with whom they even had conversations. Sometimes flocking around by the dozens, the porpoises "would crisscross the bow of the boat, then turn their heads and look up at us." Gibson and the others took photographs and movies of the journey, except during bad storms when spray could damage cameras. (A film of the trip will eventually appear on New Jersey Public Television.) Gibson, an amateur naturalist, paid special attention to birds and fish; he also collected samples of marine life and daily water temperatures.

Eastward they followed prevailing winds, intending to call at the Azores. But a tremendous gale drove them off course and impeded navigation by eye and hand. They missed the Azores by only 40 miles. "I'm still kicking myself for that," Gibson says. Nevertheless, the ARGOS tracking system showed them to have followed their intended course amazingly well overall. As they had planned, they sighted land about 100 miles north of Dakar and followed the coast south until they reached the city's harbor. Landfall itself could have been hazardous, for there were no lights along the coast. "You can't miss Africa," sailors say; but Gibson points out that it's a big continent and Dakar is one small spot on it.

Before landfall, Gibson wrote, "As we sailed south along the beach, we could see small villages—and people!... We began to see landmarks and were sure we were not far from Dakar. We saw a beacon light at night, so for the first time were absolutely sure of our posi-

tion! We would be there in the morning! Couldn't sleep for the excitement!" After landfall: "Senegal is a very poor country, and prices are high. We wanted to jump ship for our two-week stay, and live it up in a downtown hotel after the rigors of the trip, but our balloon burst when we learned the prices. We are still living on the boat, eating most of our meals aboard, and taking sponge baths..." Dakar itself was, perhaps, an anti-climax.

Determined to make the most of his stay, Gibson looked for a safari and found one through a game reserve where the only shooting is with cameras. After this trip through the bush, he returned to the boat for the return voyage.

Coming home always seems easier than going away. In the case of the *Navstar*, this psychological truth was reinforced by the calmer weather of the South Atlantic. Instead of going 100 miles per day, as they had on the eastbound journey, the crew found they were sailing 150 miles or more per day, westbound. They stopped at Cape Verde, off the coast of Africa, and liked those rocky islands, which have gone without rain for as long as 11 years at a time. The atmosphere was different there than it had been in Senegal: "After some exploring in the town," Gibson wrote, "I managed to get my shoe repaired and a fine meal. Prices are much lower here than in Dakar and the people are more industrious and busy." East of Cape Verde the *Navstar* caught the Trade Winds and "moved along briskly, with no change of sails for about ten days."

An atmospheric peculiarity caught Gibson's attention. Sunsets near Africa are yellow, not red, because of unprecipitated moisture in the air and fine Sahara dust particles that obscure visibility. As a result, the only stars they could see clearly were those directly overhead which were, fortunately, the ones they needed to sight for navigation. As they continued westward, seabirds and Portuguese men-of-war, abundant near the coast, became scarce, but whales began keeping them company.

At last they arrived at the Doldrums, an area about 600 miles east of Ber-

## Excerpts

### The Navstar Log

- June 6** Very little wind. Caught a tuna for dinner. Saw many dolphins jumping seven to eight feet out of the water. Also noted iridescent bluish flecks arising to the surface. On inspection, they were clear and gelatinous and had a black line in the center. Could these be the phosphorescent stars we see in the water at night? While we were becalmed, the sails were cracking with a loud noise as we rocked from side to side. There seemed to be a flash of light, yet it was a clear night with no evidence of lightning. Could this be a static-electrical reaction, as ion build-up was tossed off the sail?
- June 8** Sunday is pill day for our anti-malaria treatment. Started the program two weeks before our arrival in Dakar and will continue it for six Sundays after leaving Dakar. Porpoises with us at night and a beautiful sight as they stir up the phosphorescent water.
- June 9** Caught a skip jack fish today. Weather has been great since we left Dakar but winds light and seas calm. Saw more whales today. A beautiful night for stars, and the Southern Cross was brilliant.
- June 10** Marv, who was on early morning watch, woke me to see the Cape Verde Island of St. Nicholau. We island hopped to St. Vincente and arrived in its lovely deep water port of Port Grande at about 6 P.M. We were escorted into port by jumping porpoises and either pilot or pot-head whales. The Islands are stark naked, mostly rock and jagged peaks. There is little or no vegetation. The islands have been known to have gone for 11 years—without rain. They have a beauty all their own.
- June 11** In the morning Marv fixed the stove, Gary removed barnacles from the hull, and I went up the mast to repair the spreader. After some exploring down town, I managed to get my shoe repaired and a fine meal. Prices are much lower here than in Dakar, and the people are more industrious and busy. It was a very pleasant stop-over. About 3 P.M. we set sail and are immediately in the Trade Winds. We move along briskly.
- June 12** A few observations. It is strange to be facing south and at the same time have the sun behind you. The north star is so low in the sky that its magnitude is much less than in the higher latitudes. The Islands are only visible within a seven mile range even though the day seems brilliant with sunshine, and the mountains are 4000 feet high. Geology Professor Creamer explained to us that this was caused by unprecipitated moisture in the air and fine Sahara dust particles. This dust accounts for the yellow, never red, sunsets we have seen near Africa.
- June 15** Phosphorescent water, birds, Portuguese Man of Wars are getting scarce, but whales are performing near us, only about 20 feet away. Still making good time. Flying fish are getting smaller. The atmosphere is much clearer. It is getting hot, but because of continuous spray on deck, we have to wear rain gear. Ken is still sea sick but we are getting some fluids into him. I had asked the crew to supply their own motion sickness pills. This was to save me the embarrassment of my impending inability to cure the malady. But in his case I had to get involved. My only other duties as ship's surgeon had been limited to reminding the crew where to find the band aids since I refused to make house calls. It is Father's Day, and I open my card from daughter Jeanne marked "Do not open until June 15". Very thoughtful.
- June 16** Still no rain, winds are brisk and seas a little rough, but on the whole it has been great sailing since leaving Dakar.

muda, where they were becalmed for nine days. "Becalmed" is not quite the right word, however, since the boat constantly rocked back and forth, "causing the sails to crack with a noise like a shot." Any activity, even reading, became difficult. Gibson lay in his bunk "with the following thoughts: I am rocking 45 degrees to port, now 45 degrees to starboard. My skin is sticky from salt and sweat so it sticks to the bunk, but my bones are rolling like a tank. Suppose we roll 180 degrees, will my nose and belly button be on my back? Or if we roll 360 degrees I'll really be wound up tight." Gibson later remarked that anybody would be bored in the Doldrums "unless you were a mathematician." During this time the crew watched unceasingly for the slightest breeze and even hoped for a storm. Finally they picked up a good wind and set course for Bermuda. Gibson, by now eager to get home to his family after almost three months at sea, thought that sighting the lights of Bermuda was the biggest thrill of the trip. After a couple of days' rest, the *Navstar* started the last leg of its voyage back to Atlantic City. The only noteworthy sight after Bermuda was a big water spout that passed near the boat but caused no problems. A national tabloid picked up this detail and made a sensational "Bermuda triangle" story from it.

Late on July 17, the *Navstar* arrived off the shore of Atlantic City and spent a quiet night at sea. The next morning a flotilla of about 25 boats came out to meet them. Wives and children of the crew crowded aboard a small Coast Guard cutter that circled the *Navstar* as it approached the harbor. Helicopters flew above, filled with photographers snapping pictures. It was a highly dramatic finish to the voyage. On the dock were a brass-band, members of the public and the press, waiting to give the crew a rousing welcome. They opened the sealed bag of instruments at the dock. So ended the maiden voyage of the *Navstar*.

Did Gibson feel that returning to family life and coastal sailing was anticlimactic? Definitely not. He finds the waters and harbors of Maine so beau-





B. Vartan Boyajian

*The Frank S. Farley Marina was the site of the welcoming ceremonies for the crew of the Navstar.*

*Mrs. Gibson, perched far left on the bough of the Coast Guard cutter, joined other family members in the welcoming flotilla. Below Dr. and Mrs. Gibson just after the Marina arrival.*



Gregg Kohl



Linda A. Rabben



- June 20** Have been running with reefed main and Yankee sail since we left Cape Verde Islands. Still using rain gear on deck because of spray. Feel that we are about 1200 miles from Bermuda. Saw a ship at about 12:30 last night.
- June 25** Winds 35 knots and raining hard. The first rain in nearly six weeks. We are being pushed north by southwest winds. Storm ended about noon and we entered a complete calm.
- June 26** DOLDRUMS. Slight air movement about noon. A ship from Rotterdam, the *Alphecca*, changed course and came along side. They gave us a three blast salute on the horn and the crew all waved. A great thrill!
- June 28** A little breeze out of the west. We tack but little westward progress. Made popcorn after supper.
- June 29** Beautiful weather but no wind. Just drifting with no sails. Saw 200-300 porpoises.
- July 1** No wind. Temperature 87°. Can't put up sails because ship rocks from side to side causing the sails to crack with a noise like a shot. In the doldrums the boat rolls constantly from the motion of the waves. Reading and sitting are difficult.
- July 2** DOLDRUMS. Temperature 90° in cabin. Sea is like glass. I never knew it could look like this in the middle of the Atlantic Ocean.
- July 3** A slight movement of air. We put up all our light sails including handkerchiefs. Tonight we finally see a great phenomenon, the Green Flash, as described in Bowditch's book. We have been watching for it the whole trip. The sun shows a green flash just as it sinks below the horizon. Conditions must be perfect, with no clouds and a brilliant clear horizon. It can also be seen at the moment of sunrise.
- July 4** Happy 4th of July! Made good mileage today.
- July 9** My biggest thrill of the trip. I was on watch near midnight and spotted the lights of Bermuda on our starboard. Changed course slightly and after about an hour there was no doubt about it. No one slept the rest of the night and we entered St. George's Harbor about 6:30 A.M. The customs officer, Mr. Barclay, remembered me from my trip there last spring in my own boat, the *Hebanje*. Gary and I took a bus to Hamilton where we bought a beer, ice cream, ice cream soda, coke and hamburger, not necessarily in that order.
- July 11** Set sail for Atlantic City at 8:30 A.M. Weather poor. About 50 miles out we spotted a water spout about 100 feet astern. Had a severe electrical storm that night. Had to change the head sail from working jib to storm jib with lightning crackling all around me as I undid the hanks from the wire head stay. Dry mouth disease set in again. I could picture myself being fried to the head stay. Marv and I were on deck duty and the lightning ahead was getting worse. We looked at each other and quickly agreed that it would be better to tack. I have great confidence in our ability in heavy seas and high winds, but lightning, NO. No sleep this night.
- July 14** Had a visit from a cow bird who stayed on board for 36 hours. We fed him. Good wind and beautiful night. Saw the new moon sink below the horizon. Took a star sighting on Vega.
- July 16** Very rough sea and winds 25 knots. Boat uncomfortable, and I was thrown across the cabin and landed on a box. Out of commission the rest of the day. Possible fracture of ribs. At night saw Delaware Bay Light and proceeded on a more northerly course. Off course a little because of storm the previous night and morning.
- July 17** Saw Ocean City beaches and travelled north to Atlantic City. Layed off shore through storm at night until morning.
- July 18** Escorted to Atlantic City inlet by flotilla of Coast Guard boats, private yachts, and helicopters. Good to be back!

From Newagen, Maine  
Edgar T. Gibson, First Mate

tiful that he is perfectly content to sail there. In fact, within three weeks after his return, he was on another cruise, with members of the Boothbay Harbor Yacht Club. All the household projects he'd left behind for three months were waiting to be finished and Gibson is too active a retiree to let them pile up for long. Coastal sailing provides not only excitement and challenge, but a brief respite from his work around the house, a comfortable cottage on the beach with a panoramic view of the sea.

Although Professor Creamer talks of circumnavigating the world without instruments, Gibson is not keen to go along on such a trip. "It means a year and a half or two away from the family," he says "and that might be all right for a loner, but I'm not a loner." Mrs. Gibson, who, unlike her husband, does get seasick, is still a fairly enthusiastic sailor, as are their four daughters. (One daughter, married to a lobsterman, goes out to sea during Maine's cold winters to help her husband.) Dr. and Mrs. Gibson have used retirement as a means of pursuing their many lively interests.

As for the voyage of the *Navstar*, what did it prove after all? First, that ancient or primitive mariners could have travelled vast distances with carefully developed observational skills and deep understanding of the marine environment, even though they did not have accurate timepieces or sophisticated navigational instruments and techniques. Second, that a shipwrecked sailor can use nature's cues to guide himself to shipping lanes in order to be rescued. Third, that the ARGOS tracking system works over a distance of 4,000 miles east of its normal range. And finally, that human beings can use their qualities of determination, observation, courage and cooperation to accomplish difficult and dangerous tasks.

Gibson says he and the other crew members do not consider themselves experts. "Just think of ancient sailors who went to sea at the age of 14 and navigated without instruments all their lives." The voyage of the *Navstar* still ranks as an impressive achievement, not only in scientific but in human terms. "If there are doubters," Gibson says, "let 'em try it."

# President Cleveland's Lesion

## New Evidence Uncovered

by John J. Brooks, M.D. '74 and Horatio T. Enterline, M.D.

To this day the diagnosis of a tumor removed from a president of the United States remains clouded in mystery. The patient was President Grover Cleveland, the year, 1893. Aside from the secrecy which surrounded the operation for the next quarter century, conflicting accounts by the participants have caused confusion as to the diagnosis of the President's disease. Exactly what was removed from Mr. Cleveland at that time has remained a puzzle to this day. Was the ulcerating lesion of the palate actually a tumor, or could it have been some benign inflammatory condition? If it was a tumor, exactly what pathologic entity, in modern terms, did it represent? Was the lesion benign or malignant? If malignant, was it a carcinoma or a sarcoma? If malignant, why was there no recurrence in the remaining 15 years of Cleveland's life?

In an attempt to resolve these questions of historical and medical interest, we have reviewed the entire history of President Cleveland's operation and have subjected the excised tissue to modern pathologic examination and interpretation. In order to present this matter in an orderly fashion, we shall first attempt to set the historical stage, and then detail all aspects of the illness, using the form of the standard case report. Before describing the actual lesion, we shall review the conflicting original diagnoses. In addition, we shall summarize the history of prior requests to obtain diagnostic tissue from the Mütter Museum. (JAB, Spring 1978)

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*This study, reprinted with permission of the College of Physicians' Transactions & Studies, March 1980, was initiated in 1975 by the late Gonzalo E. Aponte, M.D. '52, Chairman of the Department of Pathology at Jefferson, when he was Chairman of the Committee on the Mütter Museum. The authors acknowledge his contributions and dedicate this article to him. Dr. Brooks, Jefferson class of 1974, is Assistant Professor of Pathology and Dr. Enterline is Professor of Pathology and Director of Surgical Pathology at the Hospital of the University of Pennsylvania. The authors have donated the histological slides and paraffin blocks made from Cleveland's tissue to the Mütter Museum so that the entire case shall be safely stored as a unit.*

### *Historical Setting*

The complete story of the secret operations on President Grover Cleveland has been detailed in numerous articles and will not be repeated here. However, a brief summary will suffice to describe the momentous events which set the historical stage, and will explain their significance and the necessity for secrecy.

Before Cleveland was elected for a second non-consecutive term, near-disastrous economic troubles were unleashed by the passage of the Sherman Silver Purchase Act of 1890. This act required the government to purchase 4.5 million ounces of silver annually. Of necessity notes were printed, fully redeemable in gold, for payment. The net effect was to drive gold out of the country. The unabated production of paper money produced rampant inflation, caused gold reserves to drop precipitously, and resulted in exportation imbalances, bankruptcies, and more than 600 bank failures. Cleveland, battling the tide of Populists and Silverites who desired free and unlimited coinage of silver as a solution, was re-elected on a platform that called for repeal of the Sherman Act and favored conservative fiscal and monetary policies. Although the inauguration of the President occurred in March 1893, steps were not seriously under way to repeal the Act until early summer.

In the midst of all this financial confusion, called the "Panic of '93," President Cleveland noticed a lesion on the roof of his mouth. Remembering that the Vice President, Adlai E. Stevenson, was a "silver man" and opposed to the repeal of the Sherman Act, the President decided that indication of ill health on his part would be seized upon as a sign of weakness. Therefore, after his dentist and the White House physician, Dr. Robert M. O'Reilly, had seen the lesion and had recommended surgical consultations, Cleveland decided to proceed with the utmost secrecy. The family physician, Dr. Joseph D. Bryant of New York, noted for his oral surgery, was asked to examine the President, which he did on June 25. Once the decision was made that the operation was necessary, the various members of the medical team were informed. Since, as is still true today, secrets were impossible to keep in the capital city, the operation would be performed outside Washington. The President suggested use of the yacht



*Oneida*, which belonged to a close friend, Commodore Elias C. Benedict, as the operating suite.

The President left Washington at 4:20 P.M. on June 30. Mrs. Cleveland did not accompany him. He travelled by train to New York City, where the yacht awaited him. The surgical team gradually assembled and also boarded there. While the yacht was on its way to the President's summer home (called Gray Gables) at Buzzards Bay, Massachusetts, the operation was performed. Besieged by reporters upon landing, the party gave no hint as to what had happened. The official word was that the President had a "bad tooth . . . extracted" and needed rest.

During the summer months, which the President spent at Gray Gables, the House of Representatives debated the repeal vigorously and at great length, and filibusters were threatened. On August 28 the House voted for repeal. It was not until October 20, nearly a month after the President had returned to Washington, that the Act was likewise repealed by the Senate. The cause of the economic depression was removed and the country gradually recovered.

When Cleveland returned to Washington, no one suspected that anything so momentous had happened to him. His speech was clear and sharp—if anything, improved. Shortly after the repeal was passed by the House, a very detailed and accurate account of the entire operation was published in the August 29 issue of *The Philadelphia Press* under the pen name "Holland." Apparently the dentist, Ferdinand Hasbrouck, had betrayed the secret and had supplied a young reporter, later identified as E. J. Edwards, with all the information. Holland's account was denied vigorously, not only by the White House but by all other participants. For example, Mr. L. Clarke Davis, Editor of the *Philadelphia Public Ledger* and a close friend of the President, wrote that Holland's statement "had a real basis of a toothache;" the story thus became discredited. For his part in this breach of secrecy, Dr. Hasbrouck was summarily dispatched his fee of \$250.00, and never spoken to again by Dr. Bryant, the captain of the surgical team. The reporter Edwards was not vindicated until 1917, when Dr. W. W. Keen, Jefferson's first Samuel D. Gross Professor of Surgery, another participant, recounted the entire incident in *The Saturday Evening Post*.

### History of Illness

In July 1893, President Grover Cleveland was 56 years of age. About two months before, he apparently began to complain of an irregularity or rough spot on the roof of his mouth. According to Dr. Keen, who was to be the chief operating surgeon, the patient

... stated that he was sure the rough place was of recent origin; that it was not there on March 4th, when he was inaugurated, but had been first observed about six or eight weeks before July 1st.

However, Allan Nevins, the historian, specifies the date on which Cleveland first noted the abnormality:

... yet on May 5, Cleveland noted a rough spot on the roof of his mouth. It gave him increasing discomfort, and on June 18th, he had it examined by

the White House physician, Dr. O'Reilly.

Although one author wrote that the lesion was painless, While there was no pain associated with it, the "rough place" on the roof of the President's mouth continued to worry him.

others have stated that the lesion was annoying and irritating, and that the President described his mouth as being "afire." Aside from this complaint the President felt well, and none of his biographies mentions major previous illness.

This lesion was treated initially by Dr. R. M. O'Reilly, the White House physician, with iodides and bichloride of mercury. A letter from Dr. O'Reilly to Dr. Bryant dated June 25, 1893 reports that the patient is

... taking 120 grains iodide daily, and 3/16 bichloride. He sleeps and eats well. The injections have been made daily, and a portion of the ulcer is pretty well stained. They give him pain at times, but that subsides quickly. I fancy the sore looks a trifle better.

The use of iodides and bichloride of mercury is not to be interpreted as indicative of syphilis; these drugs were prescribed for any number of ailments at that time. In addition, pyoktanin, a methyl-violet dye reputed to have analgesic and anti-infective properties, was injected into the ulcer. These measures appeared to have some beneficial effect upon the palatal lesion, for by June 27, 1893, Dr. O'Reilly is

... decidedly of the opinion that there are evidences of healing around the margin.

The patient was taking no other medicines. He occasionally drank whiskey and often smoked cigars. His family history was non-contributory.

### Physical Examination

The patient is described as being 56 years of age, and "very corpulent, with a short, thick neck." Examination of the oral cavity on Sunday, June 18, by Dr. O'Reilly, later Surgeon General of the United States Army, revealed ... an ulcer as large as a quarter of a dollar, extending from the molar teeth to within one third of an inch of the middle line, and encroaching slightly on the soft palate, and some diseased bone.

In a letter to Dr. Bryant written on June 19, Dr. O'Reilly elaborated:

I saw little but that the gum had receded from the first molar, and that there was a sinus opening on the palate. I had the dentist look at it the next day, and he reported to me that it was not caused by the tooth or by tartar. ... Yesterday morning I saw him, and by a good light. He has an ulcerative surface nearly as large as a quarter, with cauliflower granulations and crater edges, with at least one sinus extending to the bone, which is apparently roughened.

Dr. Keen examined the oral cavity subsequently and found: On the left side of the roof of the mouth, there is an ulcer beginning at the second bicuspid tooth, and extending to the posterior edge of the last molar.

Transversely, it reaches to within one third of an inch of the middle line. The edges are slightly thickened, and surface covered with a granular erosion, elevated but little above the surface of the mucous membrane of the gum. Posterior to the growth, there is an area of induration extending into the upper part of the soft palate to a slight extent. The growth is very clearly an epithelioma.

The remainder of the physical examination, performed on July 1, 1893, by Dr. Edward G. Janeway, the prominent New York physician, was recorded by Dr. O'Reilly as follows:

[Dr. Janeway] found the lungs healthy, the respiratory murmur normal, no rales audible, the heart sounds free from any adventitious murmur, the impulse difficult to obtain on account of the amount of precordial fat. The first sound clear, the second sound now intensified, the exact sounds are difficult to determine on account of adipose. . . . He [the President] replies that he puffs a little going up stairs, but that he has not been troubled by an definite shortness of breath when quiet or by exertion.

Concerning Dr. Janeway's examination, Dr. Keen recalled that

Dr. Janeway made a most careful examination of his chest, and found nothing wrong. There was little if any arteriosclerosis. His pulse was 90. His kidneys were almost entirely normal.

Exactly how the renal examination was performed is not known, but Dr. O'Reilly stated:

The urinary examinations show beginning chronic nephritis which is not a result of the urea interfering with the renal function, but which is sufficient to make us cautious about the administration of ether for fear of having a possible accident.

Dr. John F. Erdmann, Dr. Bryant's assistant, later stated that Mr. Cleveland's teeth were unusually strong, and that he had a complete set in the upper jaw.

On June 19, 1893, Dr. O'Reilly biopsied the lesion and sent it to the Army Medical Museum. There the pathologist, Dr. William H. Welch, completely ignorant of its unusual origin, examined it and diagnosed it as having "no positive proofs of malignancy . . . [but a] probable . . . epithelioma." Despite the lack of a firm diagnosis, Dr. Bryant and the others continued to suspect malignancy. Indeed, when Mr. Cleveland asked Dr. Bryant what course of action should be taken, Dr. Bryant responded, "Were it in my mouth, I would have it removed at once." Apparently there was no further discussion of the matter, and the President, together with his physicians, decided to proceed with the operation.

### ***The First Operation***

As already stated, the operation was performed on the yacht *Oneida* en route to Buzzards Bay. Drs. Keen, Bryant, Erdmann, O'Reilly, and Hasbrouck were in attendance. The ship's steward acted as surgical nurse. The patient was seated in the operating chair at 12:31 P.M., July 1, 1893. Nitrous oxide gas was begun at 12:32 P.M., ether at 1:14

P.M. The operation was finished by 1:55 P.M. What can be called an operative note is given by Dr. Keen:

Dr. Hasbrouck first extracted the two left upper bicuspid teeth under nitrous oxide. Dr. Bryant made the necessary incisions in the roof of the mouth, also under nitrous oxide.

At 1:14 P.M., ether was given by Dr. O'Reilly. During the entire operation, Dr. Janeway kept close watch on the pulse and general condition. Dr. Bryant performed the operation, assisted by myself and Dr. Erdmann.

The entire left upper jaw was removed, from the first bicuspid tooth to just beyond the last molar, and nearly up to the middle line. The floor of the orbit—the cavity containing the eyeball—was not removed, as it had not yet been attacked. A small portion of the soft palate was removed. This extensive operation was decided upon because we found the antrum—the large hollow cavity in the upper jaw—was partly filled by a gelatinous mass, evidently a sarcoma. This diagnosis was later confirmed by Dr. William H. Welch, of the Johns Hopkins Hospital, who has also examined the former specimens.

Only one blood vessel was tied. Pressure, hot water, and at one point, the galvano-cautery, checked the bleeding. The hemorrhage was not large, probably about 6.0 ounces—say, a tumbler-full in all. At the close of the operation, at 1:55 P.M., the pulse was only 80. The large cavity was packed with gauze to arrest subsequent minor oozing of blood. At 2:55 P.M., a hypodermic of 1/6 of a grain of morphine was given—the only narcotic administered at any time.

. . . Mr. Cleveland's temperature after the operation was 100.8 degrees Fahrenheit, and never thereafter rose about 100.0 degrees. His pulse was usually 90 or a little over.

Important additional details concerning the extent of the lesion can be found in the "Keen Scrapbook:"

Examination . . . showed that the disease had begun around the roots of the molar teeth and had extended into the antrum from its floor. . . . on finding the invasion of the antrum it was determined to remove all the jaw except the floor of the orbit and the intermaxillary portion, which were clearly free from invasion.

The President's recovery after the operation was swift. Although he commented to Attorney General Richard Olney, "My God, they nearly killed me!" he was up and walking around on the night of the 2nd of July, and felt reasonably well the next day. After arriving at Gray Gables, Cleveland recuperated and most of the medical team dispersed. About a week after the first operation Dr. Bryant examined the operative results. Not quite satisfied that all the diseased tissue had been removed, he quickly requested the team to reassemble aboard the *Oneida*.



## The Second Operation

The second operation occurred on July 17, 16 days after the first. Dr. Keen reports that the doctors ... removed all the suspicious tissue and cauterized the entire surface with galvano-cautery. This operation was brief, and the President recovered quickly.

Much later, in 1905, Dr. Bryant stated that the purpose of the second operation was "for the sake of giving the patient the benefit of every doubt."

These two operations produced a defect in the roof of the President's mouth; it measured 2.5 inches by 13/16 inches. Since this caused great difficulty in speech, Dr. Kasson Gibson, a New York dentist, was commissioned to provide a prosthesis.

## Followup and Later Illnesses

Apparently the excision caused no subsequent problems. With the vulcanized rubber prosthesis provided by Dr. Gibson, the President's speech was "excellent, even its quality not being altered." By August 30, 1893, Dr. Bryant notes "all healed." The members of Congress noted no great change in the President's voice when he spoke to them on September 5 concerning the silver question.

The only sequela of the operation was an earache which occurred some months after the operation.

The defect continued to heal and shrink remarkably. By 1897, a cast of the palatal defect measured only 11/16 inches by 7/16 inches. The progress of healing can be judged by comparing the cast made in 1893 with that made in 1897 (Figure 1).

The President remained in good health until late in his retirement. As he was approaching the age of 70, his ... health was increasingly infirm. He suffered much from rheumatism, and was sometimes in bed for

weeks together. Thus, in the winter of 1899-1900, a severe illness lasted for several weeks ... his digestion also became increasingly troublesome. After 1900, he kept a stomach pump always at hand, and not infrequently used it.

The nature of this gastrointestinal illness is unknown. Obviously it had been present for at least seven years, until the time of Cleveland's death.

Near his death, Cleveland was "in the grip of gastrointestinal disease complicated by ailments of the heart and kidneys. Early in the spring, he was prostrated by a painful attack, and went to Lakewood to recuperate."

Possibly the President also suffered from gouty arthritis, for one historian relates that just before his death,

The country was relieved on June 23rd when a bulletin was issued at his home announcing that he was 'rapidly recovering from an attack of gout and indigestion.' This announcement was made after a visit of Dr. Bryant.

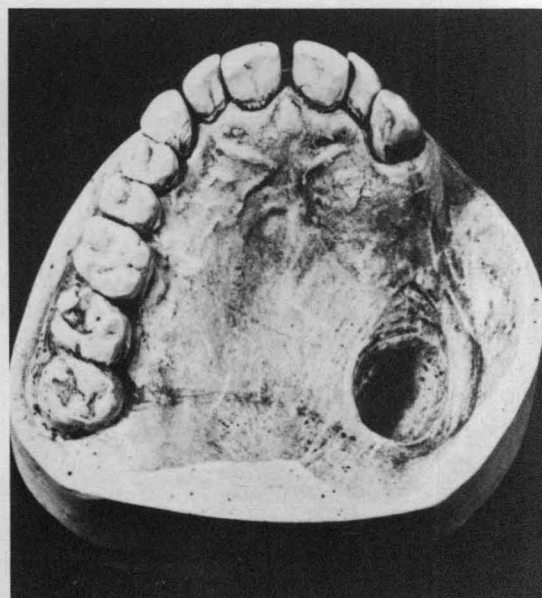
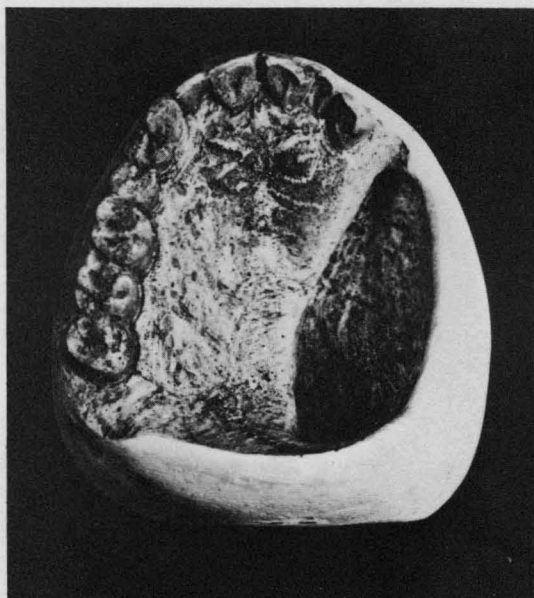
Despite the optimism related in that bulletin, Grover Cleveland died the next morning at 8:40 A.M., on June 24, 1908, 15 years after his operation. The oral disease had never recurred. According to Dr. Keen:

That he should have survived after the removal of a sarcoma of the jaw without local recurrence for so unusually long a period was a great satisfaction to Dr. Bryant and his colleagues.

The cause of President Cleveland's death is uncertain. According to one historian his death certificate is

... not accurate, listing the causes of death as 'heart failure complicated with pulmonary thrombosis and edema.' Dr. Erdmann stated that Cleveland died of an intestinal obstruction, the cause of which is not determined. He had no further symptoms or difficulty with his antral tumor.

*Cleveland's dental casts. Comparison of the cast at immediate right with the cast at far right illustrates notable healing and shrinkage of the palatal defect. (Figure 1)*



However, the *New York Herald* of June 20, 1907 (p. 3) stated that the President had been perilously ill with internal trouble, and the diagnosis was said to be a malignant internal growth. Dr. Erdmann, in an interview held on September 13, 1916, stated that

A postmortem examination was made by Graham Lusk [William C. Lusk, not Graham], and that extensive carcinoma was found in the intestines.

**Original Pathologic Diagnoses**

At least one biopsy specimen was taken from the President's oral lesion by Dr. O'Reilly, at some time between June 13 and June 19, 1893. Dr. O'Reilly personally brought the tissues to an unnamed pathologist at the Army Medical Museum in Washington, D.C. In a letter to Dr. Bryant dated June 19, 1893, Dr. O'Reilly, writing from the Army Medical Museum, states that the pathologist

... reports while there are no positive proofs of malignancy, there are certain indications which make it probable that the specimens are from a case of epithelioma.

Dr. Welch at Johns Hopkins Hospital also examined the biopsy material. It is possible that other biopsies were made on other occasions. This can be inferred from Dr. Bryant's recollections, which state that when he examined the President on June 25 with Dr. O'Reilly

... a small piece of growth was then removed for microscopic examination, after which the final removal of the disease, and the time and place of the operative procedure, were discussed.

Whether the resection specimen was examined microscopically is unknown; very probably this was done. Dr. Keen stated that after the operation the diagnosis of sarcoma was, "later confirmed by Dr. William H. Welch of the Johns Hopkins Hospital, who had also examined the former

specimen." Other pathologists also examined the lesion in one of its forms, since in a letter to Dr. Keen, Dr. Erdmann states:

The tissue removed from the late President's jaw was examined by Dr. Herman M. Briggs and Dr. D. H. McAlpern, and Dr. Welch, all at about the same time, furthermore, I am sure that the tissues or slides were sent to Dr. McAlpern and to Dr. Briggs under an assumed name. The reports given to me verbally by Dr. Bryant were carcinoma.

Although several pathologists reviewed the material, there is no record of any reports rendered by the Army Medical Museum (now the Armed Forces Institute of Pathology), or by Johns Hopkins Hospital.

A list of all the original diagnoses made by the participants is given in the Table. It should be noted, first of all, that "epithelioma" at that time was considered the same as "carcinoma." Thus there appears to be general agreement among the four doctors who were present at the operation. The disagreement and confusion result from Dr. Keen, who stated that the lesion in the maxillary antrum, was extremely myxomatous, and dubbed it "a sarcoma."

The growth into the antrum was a gelatinous mass, apparently a myxosarcoma, and totally different in appearance from the typical epithelioma of the floor of the mouth.

Dr. Erdmann, in response to this statement, made by Dr. Keen in 1917, later stated that, "Actually, it was a carcinoma." Still later, another pathologist who reviewed the original material remembered the lesion as "an ameloblastoma" and "not malignant."

Thus, confusion as to the pathologic diagnosis began with the principals involved and has continued to this day. For example, doubt was raised in the mind of Dr. Morreels:

If this tumor was a malignant neoplasm as opposed to an inflammatory lesion, President Cleveland experienced a significant tumor-free survival. It is true that this lesion arose in a location where it was detected relatively early, and where wide excision was accomplished without sacrificing vital structures.

Dr. Morreels referred to the tumor-free survival as "significant" since the absence of recurrent or metastatic disease is distinctly unusual in ordinary oral cancer (squamous cell carcinoma.) Many physicians entertained the possibility that the tumor was not the typical oral cancer but perhaps some other type of slow-growing benign tumor. For example, Dr. William M. Shelley of Johns Hopkins Hospital stated that:

By reading between the lines, I am beginning to suspect that the tumor probably was an accessory gland tumor of some sort, perhaps a mixed tumor.

Even the neoplastic nature of the lesion has been questioned and the possibility of gumma, the inflammatory lesion of tertiary syphilis, was mentioned. The fact that the lesion was said to have healed somewhat preoperatively further complicates the issue and lends credence to such interpretations. Since Cleveland's death, then, there has been much specula-

**DIAGNOSES OF PRESIDENT CLEVELAND'S  
ORAL LESION**

**A. By principals:**

- William W. Keen, M.D.: sarcoma, epithelioma
- Joseph D. Bryant, M.D.: epithelial cancer
- Robert M. O'Reilly, M.D.: epithelioma
- John F. Erdmann, M.D.: carcinoma

**B. Subsequent speculations by other physicians:**

- |                 |                    |
|-----------------|--------------------|
| not malignant   | carcinoma          |
| ameloblastoma   | sarcoma            |
| osteosarcoma    | epulis             |
| mixed tumor,    | granuloma          |
| accessory gland | syphilis           |
| gumma           | benign mixed tumor |



tion by pathologists as to the true nature of the lesion. The diagnoses suggested are listed in the Table.

These lingering doubts have led several pathologists to request the opportunity to review and perhaps improve the diagnosis. Probably considerations of delicacy prompted the denial of these requests by the Mütter Museum of the College of Physicians of Philadelphia where the tissue had been deposited. After the death of the President's last living immediate relative, his son Richard, specimens were finally obtained by Dr. Aponte and Dr. Enterline.

### **Gross Description**

Undoubtedly the tissue removed during the original resection was subjected to pathologic study. However, like the biopsy material discussed above, the original sections and the corresponding paraffin blocks of this material have been lost. What remained of the specimen was donated to the Mütter Museum of the College of Physicians of Philadelphia by Dr. Kasson C. Gibson through Dr. Keen on October 5, 1917. The tissue had been kept over the years in a small round pharmacy-like jar with a glass stopper. Although the identity of the original fixative is unknown, the specimen was in an alcohol-based fluid when we viewed it.

In 1976, pieces were examined for the first time in more than 80 years (H.T.E.). Each fragment was separately labelled, photographed, and X-rayed (Figure 2 shows one fragment). After an initial detailed gross description, appropriate specimens were taken for microscopic examination. The authors were permitted to examine the specimen with the provision that only minimal damage to it would result; therefore, only small selected fragments were subjected to histologic study. Later, in order to resolve questions relating to the extent of the lesion, the tissue was re-examined and two additional portions were removed (J.J.B.).

Subjected to histologic examination were : 1) portions of the warty palatal growths and underlying tissue; 2) sections of the anterior and posterior lines of palatal resection; 3) soft tissue representing the floor of the maxillary sinus; and finally a fragment of the palatal bone residing between the oval lesion and the soft tissue of the maxillary sinus.



*Maxillary bone with molar teeth. Note the numerous wart-like growths on the gingival surface. (Figure 2)*

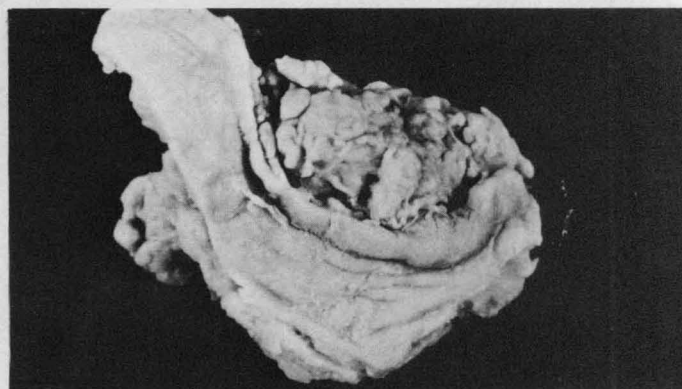
### **Microscopical Description**

Nine fragments of tissue were examined microscopically. Each of these was stained with hematoxylin and eosin, periodic acid-Schiff (PAS) before and after diastase, mucicarmine, Brown-Brenn Gram stain, Grocott, methenamine silver, Warthin-Starry modification of the Dieterle stain, Gridley stain, and Fite stain for acid-fast bacilli.

For the most part the tissue stained weakly with hematoxylin and eosin, a fact attributed to its age and prolonged fixation. Sections stained with PAS displayed the microscopic structure quite well. Slides stained with special microbial stains, carefully examined, failed to reveal bacteria, viral particles, tubercle bacilli, spirochetes or fungi.

The main lesion was best seen on sections from the lesion of the palate (Figure 3). At one end of the section, a mucosal lining of squamous epithelium showed mild acanthosis, elongation of epithelial pegs, and a mild chronic inflammatory infiltrate of lymphocytes and plasma cells in the submucosa. On the mucosal surface this acanthotic squamous mucosa was replaced abruptly by sheets of epithelial cells, which projected above the surface of the mucosa in papillary fronds (Figure 4) corresponding to the wart-like growths apparent grossly. In the submucosa, elongated finger-like nests of infiltrating epithelial cells with occasional central necrosis were noted. These club-shaped epithelial sheets could be seen to infiltrate the tissue to a depth of approximately 8.0 to 9.0 mm., particularly within the fibrous septa of minor salivary gland tissue. Indeed, certain lobules of these glands appeared nearly surrounded by tumor, which could also be seen to extend extremely close to large nerve bundles and vascular structures. Superficial ulceration of the tumor was seen.

The cells composing the papillary fronds and the infiltrating nests were composed of stratified squamous epithelial cells with well-differentiated cell borders and intercellular bridges. Many well-formed squamous pearls were present; some of these lacked nuclei (Figure 5). Prominent hyperkeratosis and parakeratosis were evident on the papillary surface. While the nuclei displayed hyperchromatism, only minimal nuclear pleomorphism was noted, especially at or near the surface. Mild variation in nuclear size and shape was observed in the deeper infiltrating areas.



*The principal ulcerous lesion on the hard palate. The mucosal outline is crescentic. Many finger-like excrescences project upward. (Figure 3)*

No evidence of glandular differentiation was seen.

Similar well-differentiated squamous epithelial cells growing in papillary formation comprised the verrucous gingival growths between the molar teeth. Again, the nuclear morphology was bland.

The tumor was everywhere accompanied by a dense inflammatory reaction of lymphocytes and plasma cells, so much so that in some areas, no sharp distinction could be made between tumor and stroma. No abnormal or neoplastic stromal cells were demonstrated, nor was any evidence of individual cell invasion detected.

The margins of the neoplasm did not extend to the "deep" margin of resection, which here would be the palatal bone.

The tumor ended 2.0 to 3.0 mm. short of the palatal bone, at least in the tissue examined. Anteriorly revealed the tumor to be extending to within approximately 2.0 mm. of the line of resection. Here again the uninvolved mucosal surface was nonetheless inflamed and acanthotic. Examination of the section from the posterior margin disclosed only acanthosis and parakeratosis; no tumor was seen.

It was surprising to find epithelial cells in nests and papillary folds in the tissue from the superior surface of the maxillary bony resection; this may have represented tumor near the roots of the molars medially. However, a more satisfying explanation, in view of the subsequent course, is that this finding was artifactual.

Sections taken from the soft tissue of the floor of the maxillary sinus were lined on one surface by respiratory epithelium. Beneath the mucosa, extensive interstitial edema and a marked perivascular and interstitial inflammatory infiltrate were found. Numerous plasma cells and lymphocytes together with occasional neutrophils in a vascular stroma constituted the infiltrate. Focal mucosal ulceration was observed but no tumor was found.

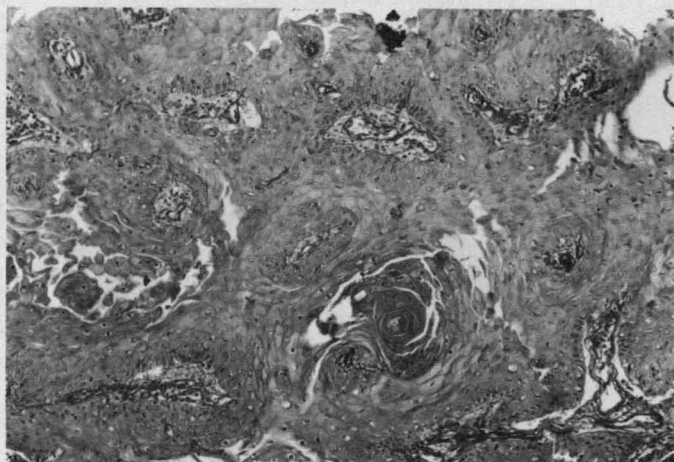
### Interpretation

Despite the conjecture mentioned above, there was no evidence that the lesion was a carcinosarcoma, mixed tu-

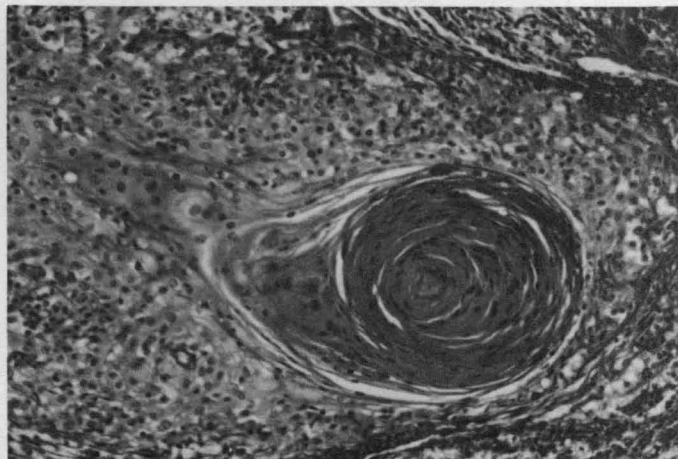
mor, or chancre, nor was there anything to support Dr. Keen's interpretation of myxosarcoma. The present authors are convinced that this neoplastic lesion is best termed a *verrucous carcinoma* of the hard palate and gingiva, and, further, that this interpretation helps to explain all the pertinent facts.

This neoplasm satisfies all the criteria of verrucous carcinoma originally outlined by Ackerman. He differentiated verrucous carcinoma from well-differentiated squamous cell carcinoma by finding in the former prominent keratin production with numerous pearls, minimal nuclear pleomorphism, blunt infiltration by club-shaped extensions, and a prominent inflammatory infiltrate. All these features were demonstrated in Cleveland's neoplasm. In addition there were no microscopic findings incompatible with this diagnosis, i.e., no single-cell invasion or undifferentiated areas could be identified. The lesion was excised completely, and did not involve the suspicious-appearing palatal bone. Our other diagnoses include hyperkeratosis and parakeratosis of oral mucosa ("leukoplakia"), mild chronic sialadenitis, caries, and dental plaque.

Verrucous carcinoma accounts for two to four per cent of all oral carcinomas. More than 75 per cent of the cases are found in men, and the average age at diagnosis is 66. As in other oral cancers, there is a clear association with chewing tobacco, snuff, alcohol and poor dentition. Although it can occur elsewhere in the body, e.g., in the larynx and cervix, verrucous carcinoma is most commonly found in the oral cavity. Characteristically, the tumor presents as a painless sore, present perhaps for years, which suddenly appears to grow more rapidly, and in a few months produces a cauliflower-like lesion; exactly the same description was given by Dr. O'Reilly. As in the present case, many of these tumors are two to five cm. in size. While the most common oral location is the mandibular sulcus, some tumors arise on the alveolar ridge or hard palate. That the lesion is malignant is evident from its rare ability to metastasize to lymph nodes and to invade bone locally, nonetheless, verrucous carcinoma has a low biologic potential. Nowadays, surgical oper-



Photomicrograph of surface growths. Although cut parallel to the mucosal surface, papillary fronds are seen, with extensive parakeratosis and hyperkeratosis. (Figure 4)



Photomicrograph of tumor. This large squamous pearl is situated in an invading tongue of tumor, which has elicited a marked inflammatory response. (Figure 5)



ation is often used as the sole method of treatment, occasionally radiation therapy is added.

Recurrence of the tumor, found in about 15 per cent of cases, is often due to the development of a second multicentric lesion. The prognosis is excellent—almost all patients survive for five years, compared to less than 50 per cent for standard squamous cell carcinomas.

In summary, verrucous carcinoma is a well-defined clinicopathologic entity, clearly distinguished from the more common squamous carcinoma of the oral cavity.

## Discussion

Confident of our diagnosis of verrucous carcinoma, we shall now attempt to explain certain clinical and pathologic aspects of the case.

First, from the clinical standpoint, verrucous carcinomas of the oral cavity can often be found not uncommonly on the hard palate and gingival mucosa, as already stated. Second, they are often asymptomatic for long periods prior to treatment; this explains why Mr. Cleveland noticed the lesion only eight weeks before the operation. Third, it is the late ulceration and resultant irritation of the lesion which draws the patient to the physician, as described in this case. Fourth, the verrucous appearance of the lesion led Dr. O'Reilly to use the word "cauliflower" in describing it. Fifth, the lack of cervical adenopathy at presentation is not surprising in view of the extremely low metastatic potential of the neoplasm. Lastly, complete surgical excision alone is often curative; this is a point of contrast with the standard oral squamous cell carcinoma. As far as we can determine, the lesion was excised completely—a tribute to surgeons who lacked the modern frozen-section technique. Thus, President Cleveland lived free from recurrence for 15 years.

In addition, certain pathologic problems in the case are elucidated by the fact that the lesion was verrucous carcinoma. While Dr. Keen had called the maxillary sinus tissue "myxosarcoma" because of its soft flesh-like "gelatinous" character, we now attribute this to florid edema and inflammatory reaction secondary to the carcinoma. Probably the entire mucosal surface at the bottom of the maxillary sinus appeared to be thrown up into watery nodular elevations, and this led to Dr. Keen's misinterpretation.

It is now well recognized that underdiagnosis of verrucous carcinoma occurs, especially when biopsies have been done superficially. The hesitation of the pathologist, Dr. Welch, to call Cleveland's tumor an outright malignancy thus becomes easy to understand. Undoubtedly Dr. Welch had received only a small superficial portion of the tumor, in which invasion could not be detected.

Because President Cleveland lived for many years and had no recurrence, later physicians and pathologists alike inferred that the resected lesion might not have been the ordinary oral carcinoma. Thus began the numerous speculations as to the true diagnosis. Suggestions ranged from inflammatory lesions such as syphilitic gumma to benign neoplasms such as mixed tumor of the salivary glands. The verrucous nature of the neoplasm explains the lack of recurrence or metastasis.

Finally, the etiology of the lesion can now be stated. It is well known nowadays that squamous cell carcinomas of the mouth and verrucous carcinomas in particular are often associated with the use of tobacco and alcohol, both of which were used by President Cleveland. Many passages in Cleveland's biographies document this fact. For instance, Nevins writes:

He was happiest in a hotel lodge; in a friend's room full of tobacco smoke, glasses, and cards...

and again:

... Cleveland... was a sparing eater, but he appreciated a well-cooked dinner of the German type...

Spirits he drank occasionally, but beer constantly.

The former President was far from being a teetotaler, although he certainly was not an abuser of alcohol. Nevins relates a humorous incident:

Cleveland returned from Exposition Park through a sea of mud, and in a driving rain. He was to be entertained that evening at the home of Senator Colquitt, who had been a Methodist minister and was one of the pioneer prohibitionists of the South. Cleveland was cold and wet when he arrived. His first words after shaking hands... were, 'Senator, I must have a drink right away.' The astounded Colquitt was... nonplussed. He said 'There hadn't been a drop of liquor in the house since I lived in it,' but a neighbor across the street supplied some bourbon, and in a moment the President had the only drink that Colquitt ever served in his life.

On the night before the operation the President indulged:

On arriving on the yacht, the President lighted a cigar, and we sat down on the deck, smoking and chatting until near midnight.

This led Bennett to make the statement that:

Cleveland smoked cigars heavily, a practice which may have caused his condition.

## Summary

Up to now, all accounts of the diagnosis of President Cleveland's disease have been based on hearsay. Although many serious questions concerning the nature of the lesion have been raised in the last 80 years, we believe they are resolved by our diagnosis of verrucous carcinoma, a low-grade malignant tumor known to behave more mildly than the ordinary oral cancer. The symptoms, clinical presentation, medical diagnoses, and lack of recurrence can all be explained on this basis.

The possibility that the former President died of cancer is not eliminated. As yet, we have been unable to find either the tissues obtained at autopsy or the autopsy report. The long post-operative survival—15 years—and the known biological behavior of the oral neoplasm make it improbable that the latter was the source of Mr. Cleveland's terminal gastrointestinal symptoms. The character of the original tumor and the skill and aggressiveness of the surgeons combine to explain the successful outcome of the primary illness.

*References upon request, Alumni Office, JMC.*

# class notes

## 1920

**Louis F. Burkley, Jr.**, 452 Berwick St., Easton, Pa., is enjoying his ninth year of retirement. "A pleasure in a way to get away from the life of 50 years as an obstetrician."

## 1927

**Samuel M. Dodek**, 5480 Wisconsin Ave., Washington, D.C., is the 1980 recipient of the Medical Society of the District of Columbia's Certificate of Meritorious Service Award. The award is presented to a member of the Society in recognition of distinguished service to the medical profession.

## 1928

**Lundie C. Ogburn**, 3221 Merion Ct., Winston-Salem, N.C., is enjoying a 40-hour work week as a gynecologist and surgeon. Dr. Ogburn has pulled a travel trailer 95,000 miles in the past ten years and expects to continue next year.

## 1929

**Mario A. Castallo**, 1621 Spruce St., Philadelphia, was interviewed for a half hour Thanksgiving Day broadcast by the Physician's Radio Network (PRN). One of two Pennsylvania physicians chosen he spoke on his views of medicine today and yesterday.

## 1931

**Oscar R. Deutal**, 265 Newark Ave., Bloomfield, N.J., was honored on November 9 when 150 friends, patients and colleagues gathered for a dinner at the Friar Tuck Inn in Cedar Groves. Dr. Deutal, a general practitioner, has maintained an office there for 50 years. He serves on the staffs of Presbyterian, Clara Maass Memorial and Mountainside Hospitals.

**John T. Murphy**, Connell Bldg., Scranton, Pa., has been named a member of the Marywood College Board of Trustees.

## 1932

**William T. Rice**, 262 Connecticut Ave., Rochester, Pa., is still in the private practice of radiology there. "Hope to make our 50th."

## 1933

**C. Perry Cleaver**, 250 Main St., Catawissa, Pa., is Chairman of the Quality Assurance Committee of the Bloomsburg Hospital.

**Anthony J. Ruppertsberg, Jr.**, 332 E. State St., Columbus, Oh., is an Emeritus Professor of Obstetrics and Gynecology at Ohio State University and is Secretary of the Ohio State Medical Board of Licensure.

## 1936

**Gabriel E. DeCicco**, 1028 Westport Dr., Youngstown, Oh., had surgery last November. Alfred L. Hoffmaster '36 visited Dr. DeCicco in the Hospital and his son Reed Hoffmaster performed the surgery. Dr. DeCicco hopes to make the 45th reunion next year.

## 1937

**Coe T. Swift**, 21 Heritage Ct., Belmont, Ca., has retired from general practice. Dr. Swift had practiced in Madera, California since 1938.

## 1941

**John Y. Templeton, III**, 111 S. 11th St., Suite 6255, Philadelphia, is the newly elected President of the Thomas Jefferson University Hospital staff. He is also Chairman of the Pennsylvania Medical Society Constitution and Bylaws Committee.

## 1942

**Robert A. Heinbach**, Box 26, Selingsgrove, Pa., writes that his son, Robert Jr., is winding up a residency in ob-gyn at Reading Hospital.

**Joseph W. Stayman**, who is residing in Landrum, S.C., following his retirement as Director of Surgery at Chestnut Hill Hospital in Philadelphia, has been named Emeritus Clinical Professor at Jefferson.

## 1943

**Warren R. Lang**, 1930 Chestnut St., Philadelphia, Acting Chairman of the Department of Pathology at Jefferson, is Secretary-Treasurer of the American Society of Cytology.

## 1944J

**Robert L. Breckenridge**, 13 Cunningham Ln., Cherry Hill, N.J., Professor of Pathology at Jefferson, is serving as President of the American Pathology Foundation.

## 1945

**J. Elder Bryan, Jr.**, 7926 3rd St., Downey, Ca., writes "ask your Congressman for a copy of HR5929/96th Congress, a common sense method of helping patients cope with the cost of their health care. If you find it a viable philosophy, contact me for details."

**John J. Cox**, 501 Haddon Ave., Haddonfield, N.J., was promoted to Assistant Professor of Clinical Medicine at Jefferson in July.

**William T. Lineberry**, 1890 Edgecliff Dr., Fullerton, Ca., is working in the Industrial Medical Department of the Gallatin Medical Clinic in nearby Downey. His oldest daughter is taking a pre-nursing course with hopes of starting nursing school next year and his youngest daughter should graduate with a triple business major in December. She is an amateur photographer like her Dad.



## 1946

**Samuel D. Rowley**, Hibernia Rt., Green Cove Springs, Fl., has been installed as President of the Florida Public Health Association. Dr. Rowley has been Director of the Public Health Division of the city of Jacksonville since 1973.

**Frederick Urbach**, 3322 N. Broad St., Philadelphia, was elected to a four year term as President of the Association Internationale de Photobiologie, a nonprofit organization created to stimulate research in the physics, chemistry and climatology of nonionizing radiation (ultraviolet, visible and infrared) and its biologic effects and applications in biology and medicine. Dr. Urbach is a Professor and Chairman of the Dermatology Department at Temple University Health Sciences Center and Medical Director of the Skin and Cancer Hospital. His research is concerned with the relationship between exposure to sunlight and the development of skin cancer.

## 1948

**Chester F. Cullen**, 27 Fernwood Rd., West Hartford, Ct., notes that his son, Michael, is a sophomore at Jefferson.

## 1949

**Gerald Marks**, 111 S. 11th St. 8254, Philadelphia, was Chairman of a six hour Postgraduate Course in Colon and Rectal Surgery at the College of Surgeons October meeting in Atlanta. He also presented two papers titled "Radiation Injured Intestine: The Challenge and the Response" and "To Snare or Resect."

**Robert E. T. Stark**, 15 E. Country Club Dr., Phoenix, has been elected to a three year term as a Trustee of the American Society of Bariatric Physicians. He also serves on the Advisory Committee for Continuing Medical Education of the AMA and is Chairman of the Arizona Medical Association's Medical Education Committee.

## 1950

**Carter F. Cort**, 956 Coleman Ave., Fairmont, W. Va., announces his marriage to Doreen Greenfield.

**James R. Hodge**, 295 Pembroke Rd., Akron, Oh., Chairman of the Department of Psychiatry at Akron City Hospital and Professor of Psychiatry at Northeastern Ohio University's College of Medicine, attended the Annual Meeting of the American Academy of Psychosomatic Medicine in Miami, Florida, in October where he was made a Fellow in the Academy of Psychosomatic Medicine.



*Paul A. Bowers, M.D. '37, (right) past President of the Alumni Association, received the Abenaki Award of the Katahdin Medical and Philosophical Society from John Y. Templeton, III, M.D. '41, member of the Board of Regents. Dr. Bowers was honored for his services to medicine and to society at the annual dinner of the Society at the University Museum in Philadelphia on November 8.*



*Members of the Faculty Wives Club of Jefferson Medical College met at historic Cliveden last fall to mark the 20th anniversary of the Club's founding. Its purpose is to promote social activities and to introduce and welcome wives of new faculty members. On steps at left are Mrs. Herbert A. Luscombe, Mrs. Jacob J. Kirshner, Mrs. John J. Dowling, Mrs. Peter A. Herbut, Mrs. John J. O'Keefe, Mrs. C. Wilmer Wirts. Center row includes Mrs. Robert C. Baldrige and Mrs. Paul J. Poinard. Right row are Mrs. Paul A. Bowers, present President of the Club, Mrs. Carolyn Hunter, Mrs. Peter A. Theodos, Mrs. Basil Giletto, Mrs. Willard A. Krehl, Mrs. Paul O. Blake, Mrs. Joseph Medoff and Mrs. Audrey Knowles.*

icine. Dr. Hodge also addressed the Academy on "The Rhinoceros Principle: Paradoxical Intention in Symptom Control and Analysis." On October 23, he represented Jefferson at the inauguration of G. Benjamin Lantz, Jr. as President of Mount Union College in Alliance, Ohio.

**Robert E. Karns**, Plymouth Ln., Manchester, Ct., writes "sorry to miss the 30th but will be on hand for the 35th."

## 1951

**Morton Schwimmer**, 76 E. 94th St., New York, has been appointed an Assistant Clinical Professor of Medicine at Columbia University's College of Physician and Surgeons. He also represented Jefferson at the 50th Anniversary Convocation of Brooklyn College on November 10th at the College campus.

**Calbert T. Seebert**, 1114 Ramblewood Rd., Baltimore, responded to "the Pit revisited" with identification of an additional five members of the class of '51. He also noted that he is in his eighth year in the Department of Anesthesia at Baltimore City Hospitals, which are affiliated with Johns Hopkins.

**William E. Wallace**, 1851 Arlington St., Sarasota, Fl., retired from his practice of neurosurgery in July 1979. He is devoting his time now to the W. E. Wallace Corporation which was set up five years ago for the manufacture and marketing of a patented all over rain cape. This is just one of ten inventions developed over the past 15 years. Dr. Wallace also is working on his third novel.

## 1952

**Edward W. Ditto, III**, 625 Orchard Rd., Hagerstown, Md., is in his 26th year of family practice and writes that he enjoys every day of it. While being busy with his patients he still makes time for work on the state level.

**Warren P. Goldburgh**, 111 S. 11th St., Philadelphia, has been elected to the Board of Governors of the American Heart Association, Southeastern Pennsylvania Chapter.

**James M. Hofford**, Professional Bldg., Augustine Cut-Off, Wilmington, De., has been named to the American Lung Association Hall of Fame. He is Chief of the Department of Medicine, Section of Pulmonary Diseases at St. Francis Hospital in Wilmington and Assistant Clinical Professor of Medicine at Jefferson.

**Howard V. Huxster**, 111 North 44th St., Philadelphia, is in the private practice of psychiatry and psychoanalysis in Philadelphia and Newark, Delaware. His son, **Robert H. Huxster, M.D., '78**, is doing an orthopaedic surgery residency at Jefferson.

## 1954

**Charles H. Greenbaum**, 10125 Verree Rd., Philadelphia, is serving as Chairman of the Committee on Evaluation of the American Academy of Dermatology.

**Robert C. Lee, Jr.**, 372 Alexander Young, Honolulu, was at the new Wills Eye Hospital conference and dedication in April.

## 1955

**Eugene A. Curtin**, McAuley Bldg., 802 Jefferson, Scranton, Pa., has been appointed to the Board of Trustees of the University of Scranton. He is Director of obstetrics and gynecology at Mercy Hospital.

**H. William Porterfield**, 1100 Morse Rd., Columbus, Oh., Associate Clinical Professor of Surgery at the Ohio State University, was selected President-Elect of the American Society of Plastic and Reconstructive Surgeons. He holds certification from the American Board of Plastic Surgery, practices plastic surgery in Columbus, and is Attending Physician at Riverside Methodist Hospital and Children's Hospital. He also serves as Program Director of the Plastic Surgery Joint Residency with Ohio State University at Mt. Carmel Medical Center, is a past President of the Academy of Medicine of Columbus and Franklin County, is a member of the Columbus Surgical Society, the American Cleft Palate Association, the Ohio State Medical Association, the Ohio Valley Plastic Surgery Society, the Association of Plastic Surgeons and the American College of Surgeons. In addition, he serves as an Ohio Delegate to the American Medical Association.

## 1956

**Joseph P. Bering**, 12 Stonleigh Dr., Lebanon, Pa., writes that his son, Thomas G. Bering, graduated from the University of Pennsylvania Medical School in June 1980 and is presently an intern at Reading General Hospital in Reading, Pennsylvania.

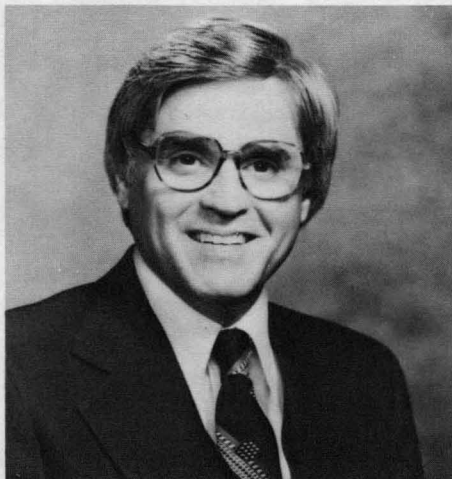
**Merlyn R. Demmy**, 16 Club House Rd., Bernville, Pa., continues to enjoy the private practice of psychiatry in Reading. His son, **Todd L. Demmy '83** is in the five year Penn State-Jefferson program.

**Paul E. Frank**, 331 N. York Rd., Hatboro, Pa., has co-authored an article that appeared in the July 1980 issue of the *Archives of Ophthalmology*. Its title is "Diffuse Primary Malignant Melanoma after Prior Primary Cutaneous Malignant Melanoma."

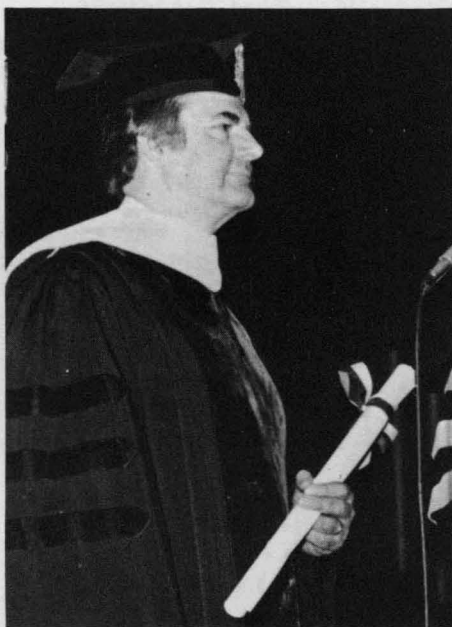
**Robert J. Maro**, Route 70 and Covered Bridge Rd., Cherry Hill, N.J., is a board certified family physician practicing in southern New Jersey. His son, Bob Jr., graduated

### Rare Books Gift

The Scott Library has received nine old and rare books, including a first edition of *Pharmacopeia of the U.S.A.* (1820) and a copy of Benjamin Rush's *Medical Inquiries and Observations* (1794) from alumnus Robert B. Jeffreys '45. None duplicated anything previously owned although three were earlier editions of works previously donated by P. Brook Bland, Professor of Obstetrics and Gynecology.



Dr. Porterfield



John W. Goldschmidt '54, has received an honorary Doctor of Science degree from the College of Allied Health Sciences at Thomas Jefferson University. He served as first Dean of the College.

from Jefferson Medical College this year. He will join his father's office upon completion of his residency.

**Ronald M. Melmed**, 3616 Sagewood Ln., Modesto, has lived happily in California since May 1978 and enjoys being free of the hassles of private practice. He was selected to be included in the 1981-82 edition of "Who's Who in California" and is looking forward to the 25th Class Reunion.

**Charles J. Stahl, III, M.D.**, 1603 Willowbrook Drive, Johnson City, TN, has been appointed Professor of Pathology at the Quillen-Disher College of Medicine, East Tennessee State University, Johnson City, as well as Chief, Laboratory Service at the Veterans Administration Medical Center. Prior to these appointments Dr. Stahl had been Chairman, Department of Laboratory Medicine, Program Director for residents in pathology and Director of the School of Medical Technology at the National Naval Medical Center, Bethesda, Maryland, as well as Consultant in Laboratory Medicine to the Surgeon General of the navy. Dr. Stahl retired from the United States Navy as a Captain, Medical Corps, last October after serving on active duty for over 25 years. During a retirement ceremony at the National Naval Medical Center on September 26 he was awarded the Legion of Merit and was appointed as Consultant in Laboratory Medicine to the National Naval Medical Center.

**Henry L. Yim**, 46-185 Nahiku St., Kaneohe, Hi., sends greetings to all his classmates from "paradise." "Thanks for all the calls."

## 1957

**Allan W. Lazar**, 740 Carroll Pl., Teaneck, N.J., married Edna Jager on October 5. They are living at the above address with six of their nine children still at home.

**Raymond G. Tronzo**, 2889 10th Ave., Lake Worth, Fl., has been appointed Chief of orthopaedic surgery at the Community Hospital of the Palm Beaches and Director of a new Center there. The new Center will be a division of a hospital devoted exclusively to artificial joint replacements. Dr. Tronzo is working on a second revision of his book, *Surgery of the Hip Joint*.

## 1958

**Gino Mori**, Lily Lake Rd., RD #2, Dalton, Pa. and his brother **Hugo Mori, '62** presented a class on abdominal and genitourinary emergencies at Scranton General Hospital to nurses, students and physicians.

**Donald E. Willard**, R.D. # 1, Phillipsburg, N.J., received the 1980 Honor Award of the American Academy of Ophthalmology dur-



# Rheumatologist's Portrait



*The portrait of Professor Nathan M. Smukler*

"Will Rogers once said he never met a man he didn't like. I think I can paraphrase this by saying I have never met a man who disliked Nate," remarked John R. Patterson '54 who delivered the Biographical Sketch at the portrait presentation ceremony for Nathan M. Smukler '47. The portrait, commissioned by colleagues to honor the Jefferson Professor of Medicine, was done by artist Robert O. Skemp. Raphael J. DeHoratius '68, Associate Professor of Medicine, a former student of Smukler's who described him as an inspiring role model, presided at the ceremony.

In his remarks, Patterson noted an early indication of Smukler's tendency to achieve; he was elected President of his first grade class! Born in Philadelphia, he is the son of Dr. and Mrs. Maximilian E. Smukler. Smukler's father was a member of the class of 1910. After receiving his bachelor of science degree in chemistry from the University of Pennsylvania in 1943, Smukler entered Jefferson. He served internships at both the Mount Sinai and Kings County Hospitals in Philadelphia. Having completed his residency at Mount Sinai Hospital in April 1951, Smukler was commissioned as a first lieutenant in the United States Army and spent two years on active duty stationed in Aberdeen, Maryland.

Following his military service, Smuk-

ler did a fellowship under Dr. Joseph Hollander in the Arthritis Section of the University of Pennsylvania Medical School. In 1954 he became a University of Pennsylvania Associate in Medicine, and in 1959 on Dr. Hollander's recommendation, he was selected as an Assistant Professor of Medicine at Jefferson and became the first full time head of the Rheumatology Division. He rose through the ranks and became a full Professor of Medicine in July 1974.

Smukler has contributed more than 26 papers and abstracts to the medical literature. His works include the Section on Arthritis and Rheumatoid Disease in the Cyclopedia of Medicine from 1956 to 1962, the Section on Osteoarthritis in Current Therapy edited by H. F. Conn, and a section entitled Arthritis of the Spine in the textbook *The Spine*.

Smukler is active in the American Medical Association, the American Federation for Clinical Research, and the American Rheumatism Association, Section of the Arthritis Foundation. In addition, he has served as President of both the Eastern Pennsylvania Chapter of the Arthritis Foundation and the Philadelphia Rheumatism Society, and he is a member of the President's Commission on Aging.

"I suspect the award that pleased him most was the Jefferson Resident's Award for excellence in bedside teach-

ing which he received in 1972 and 1974," commented Patterson who described Smukler as a man with "a totally impressive grasp of the rheumatologic literature." Patterson joked with the audience that he believed Smukler "could quote an obscure article on arthritis of chimpanzees in the orangutan medical journal!"

Patterson, whose acquaintance with Smukler goes back 20 years, described their early days in the arthritis clinic. "We were dealing with people who were dispossessed, handicapped both economically and socially and further handicapped by their disease. My enormous admiration for him came as I saw him move among these people with grace and with the same standard of care applied to these people as to the wealthiest patient in the hospital. His virtues include a remarkable humility, a total lack of guile, and a complete inability to put down another person no matter what the circumstances are." Patterson summed up Smukler's deep compassion for people with the words of a song sung in his church, "whatsoever you do to the least of my brothers you do also unto me."

Smukler and his wife Carol have three daughters: Nancy, a second year medical student at the University of Pennsylvania; Janet, a student at Drexel University; and Donna, a student at

Trinity College. Smukler enjoys swimming and jogging and according to Patterson "has the lean and hungry look of the cardiologist."

The portrait was unveiled by Mrs. Smukler who then kissed Patterson. University President Lewis W. Bluemle, who accepted the portrait on behalf of the faculty and the Board of Trustees noted, "I can't help but make two spontaneous observations at this ceremony. The first is that the good guys get kisses and administrators get the old laundry, and the second is that in listening to Dr. Patterson's remarks on Dr. Smukler's life it does reflect a relationship between the University of Pennsylvania and Jefferson which historically goes back to the man after which this auditorium was named, Dr. McClellan." Bluemle then explained that though McClellan received his early education at Penn, he had the wisdom upon reaching maturity to leave that institution for an alternative. The University of Pennsylvania, "by the same token, seems to have the wisdom to recognize good genetic inheritance by taking" Smukler's daughter into its fold!

Bluemle expressed the sentiments shared by many of those acquainted with Smukler when he said, "he personifies kind, intelligent concern for others which is perhaps the most noble quality of our profession."

ing the national meetings in Chicago in November. Dr. Willard, who earned a master's degree in bio-medical engineering at Drexel University in 1967, is affiliated with Easton Hospital in Pennsylvania. For the past ten years he has been active in teaching ophthalmic microsurgery in practical workshops and courses at universities and medical centers across the country. Dr. Willard also serves as Consultant to Ethicon, Inc., and Edward Weck and Co., producers of instruments for microsurgery. Dr. Willard is a Fellow of the American College of Surgeons and an Associate Examiner of the American Board of Ophthalmology.

## 1959

**Ronald E. Cohn**, 4940 Frankford Ave., Philadelphia, has been appointed Clinical Professor of Medicine at The Medical College of Pennsylvania. Dr. Cohn has served as Frankford Hospital's first full-time Medical Director since his appointment in June 1969.

**Charles C. McDowell**, 6425 Roselawn Rd., Richmond, Va., was promoted to Clinical Professor of Orthopaedic Surgery at the Medical College of Virginia. He also holds a similar appointment in plastic surgery.

**Martin Rubel**, 1123 Penshurst Ln., Narberth, Pa., is the Director of the Adolescent Program at the Institute of Pennsylvania Hospital and a member of the faculty of the Philadelphia Psychoanalytic Institute.

## 1961

**William F. Hook**, 1242 W. High Acres Rd., Bismarck, N.D., has taken up aviation and now flies three days per week to provide radiology services to small rural hospitals. Dr. Hook's oldest son is a sophomore at the Air Force Academy. He has two sons in high school and a daughter in the first grade.

**Gerald M. Polin**, 9805 Drouin Dr., Richmond, Va., is the Clinical Director of the Psychiatric Institute of Richmond, a child and adolescent psychiatric facility.

**Robert B. Tesh**, 60 Alston Ave., New Haven, Ct., has recently taken a position as Associate Professor in the Department of Epidemiology and Public Health at Yale University School of Medicine.

**James W. Webster, Jr.**, 508 South Temple, East, Salt Lake City, represented Jefferson at the inauguration of Jeffrey R. Holland as President of Brigham Young University on November 14.

## 1962

**Robert M. Glazer**, 415 South 19th Street, Philadelphia, was recently promoted to

Clinical Associate Professor of Orthopaedic Surgery and Clinical Associate Professor of Orthopaedic Surgery in Physical Medicine and Rehabilitation at the University of Pennsylvania School of Medicine.

**Joseph J. Pittelli**, 22 Fairway, Cranbury, N.J., has joined Ortho Pharmaceutical Corporation as Vice President of Medical Affairs. Prior to joining Ortho, he served as Vice President of Clinical Research and Medical Services for Abbott Laboratories.

## 1963

**John M. Fenlin, Jr.**, 248 S. 21st St., Philadelphia, Pa., is the newly elected Secretary Treasurer of the staff at Thomas Jefferson University Hospital.

**Melvin Yudis**, 1231 York Rd., Abington, Pa., is Physician-in-Chief of the nephrology Division at Abington Memorial Hospital and an Associate Professor of Medicine in the Nephrology Division of Hahnemann Medical College.

## 1964

**Anthony M. Harrison**, 4929 Batard St., Pittsburgh, has been elected President of the staff at Montefiore Hospital.

## 1965

**Elmer C. Bigley, Jr.**, 4921 Kingston Dr., Annapdale, Va., an orthopaedic surgeon in a group practice in Alexandria, is Secretary of the Alexandria Medical Society. Chief of staff at the National Orthopaedic and Rehabilitation Hospital in Arlington, Dr. Bigley is the recipient of the American Fracture Association's Henry Meyerding Award. He and his wife, Betty, have three children, Elmer, III, Heather Lynn and Beth Ann.

**Richard W. Cohen**, 3044 Plymstock Ln., Atlanta, is practicing orthopaedic surgery with offices in both Austell and Marietta. He is a Fellow of both the American College of Surgeons and the American Academy of Orthopaedic Surgeons. He writes that his two daughters are in college and his wife is in law school.

**Daniel G. Harwitz**, 2390 Bayview Ln., Miami, is Chairman of the Board and President of the American Health Plan, Inc., a federally qualified health maintenance plan. The address is 560 Northwest 165th Street.

**William H. Rogers**, 175 E. Brown St., E. Stroudsburg, Pa., has been elected to the International Cardiovascular Society. He is Chief of surgery at Pocono Hospital and board certified.

**Victor B. Slotnick**, 312 Melrose Rd., Merion, Pa., was made a Fellow of the Ameri-



## Internist

to

## Artist

What happens when a successful internist discovers that he'd rather be an artist than a doctor? Does he push aside the troublesome wish or tackle it head-on? For William Renzulli, '65, the issue could not be avoided. "At 35 I went into a brick wall." Depressed and unhappy, Renzulli started on what he calls a "journey" to figure out what he really wanted out of life. Meanwhile, his wife became restive, too, after years at home caring for their three daughters, and got involved in feminism. "I guess you could say I got my consciousness raised," Renzulli observes wryly. The result of her personal exploration was a decision to go to law school. He became a part-time "house-husband" when his wife started attending classes at University of Pennsylvania Law School. Responsibilities at home meant with-

drawing somewhat from his intense round of activities as a physician. Instead of attending professional society or committee meetings, he took his children to the dentist and cooked dinner.

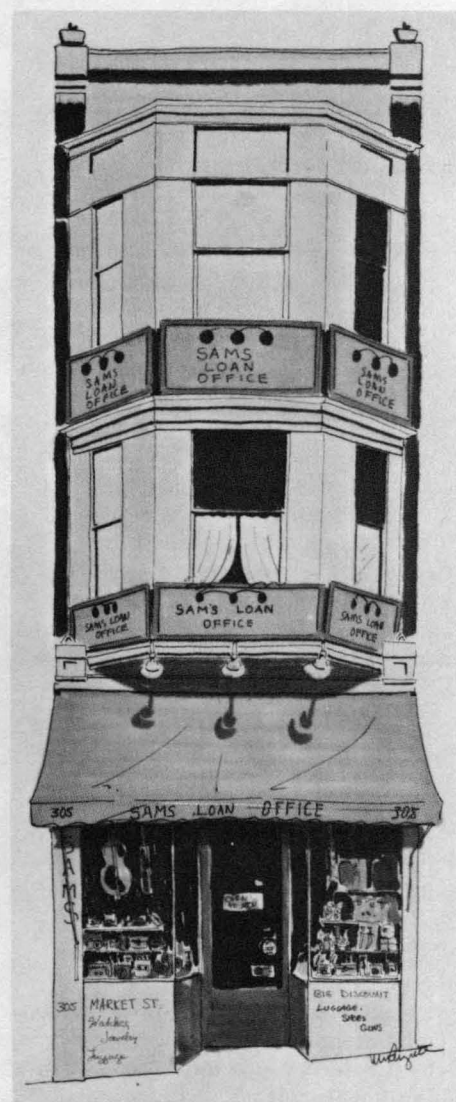
To his own surprise, domestic work was not an unbearable imposition, though making the transition to it was not always easy. "If my wife had asked me to cook or do housework years ago, I would have rejected the idea; now it just seems—reasonable." This substantial change in his life gave him the impetus to journey further. To find the roots of his discontent, he read widely, shared his thoughts and feelings with friends and sought their counsel. Out of this personal and professional ferment came a new determination: "About three years ago I began to recognize that I wanted to paint, but I couldn't admit to myself how important it was." He coped by spending two-thirds of his work week in his medical office and one-third in his studio. And he began exhibiting his paintings in Wilmington, Delaware, where he lives. At his first professional exhibit, he sold every painting he showed. Finally he realized that medicine was too consuming a profession to do part-time; and he couldn't abandon his painting. He had to choose between the two.

In late September 1980 he wrote to his patients: "It is with mixed feelings that I announce my resignation from private practice effective January 1, 1981. . . . I appreciate the trust that you have shown me by allowing me to participate in your care. Sometimes this has been a simple matter, other times very difficult, but it has always been meaningful and important to me. I have always considered it a special privilege to be allowed to share some of your concerns, burdens and pain. My life has been enriched because of this." It is clear that Renzulli's feelings for his patients are profound and sensitive; the very intensity of his involvement with the practice has made it necessary, paradoxically, to leave it.

Although Renzulli says, "It's so easy to get hung up on money, even when you don't want to," he recognizes that painting is not a good way to support a family. A headlong leap into art is, practically speaking, impossible for him, despite his success in selling his work. His wife, now practicing law in a Wilmington firm, helps, as does the family's unpretentious way of life. Their

daughters attend public schools and they live in the city, in a Victorian house that they modernized at relatively low cost ten years ago. Renzulli does not want to abandon medicine completely, either. He mentions practical reasons for taking a job as an emergency room physician, but it may be that he cannot give up the human contact medicine provides. When he talks about medicine, he calls it a "great profession." It gives the physician the chance to encounter people on all levels, he says.

In contrast, Renzulli's paintings are mostly free of human figures. He paints buildings, especially old ones, with the delicate exactitude of a miniaturist. These works he sees as "portraits" that "say something" about the "messy vitality" of urban life. In his sketches he shows spontaneity and freedom as he



experiments with line and composition. The paintings—mostly watercolors—are more meticulous, but still very accessible. It is easy to see why they attract buyers, since they simultaneously reveal control, sensitivity, even humor. They are unpretentious, colorful and at the same time just a little mysterious, perhaps because the subjects are isolated on the paper: cityscapes without people.

Renzulli goes on sketching expeditions early in the morning, when the city is quiet and its structures lie revealed. How many of us, after all, really look at the buildings surrounding us as we hurry to work or home? Renzulli's paintings are the results of what he calls "encounters" with his inanimate subjects—more intense and loving observations than most of us can allow ourselves to make in the rush of everyday existence. The turmoil he went through in order to decide to leave his medical

practice is nowhere evident in his art.

During 1981, Renzulli is going to work in the emergency room in three-month, full-time blocs, with three-month intervals for painting. With more time to devote to art, he hopes to explore the work of other artists, start painting in oils and find more of the "seed time" necessary for creative activity. His wife and family support his decision to change the shape of his—and their—life. Of his wife's work, he says, "It's hard to describe to other men the subtle change that occurs when the spouse suddenly has her own thing to do, her own space. It takes a pressure off that I never knew was there before." Renzulli has, in effect, been liberated by his wife's career. His patients may miss his care and concern, but his audience will gain the benefits of Renzulli's "journey" through the self and beyond, to the practice of art.



can Academy of Family Physicians in New Orleans.

**Richard C. Wilson**, 4384 Clearview Ci., Allentown, Pa., writes that his eldest daughter is a freshman at Boston University and his son, a junior in highschool, is a soccer player. The Wilsons ski in the area and "wage weekly war on the tennis court." I've switched from jogging to bicycling because of 'old age of the spine.'"

## 1966

**Walter S. DePalma**, 2123 Shore Rd., Linwood, N.J., has been named Director of emergency services at Shore Memorial Hospital. He has recently received notice of his certification as a Diplomat of the American Board of Emergency Medicine.

**Laurence R. LeWinn** and his wife, Maja Ruetschi, M.D., have moved from New York to Danville, Pennsylvania, to join the Geisinger Medical Center where he is Chief of reconstructive surgery and she is an Associate in the same field. Dr. LeWinn is a member of the American College of Surgeons and the American Society of Plastic and Reconstructive Surgery and former Director of the New York Hospital Hand Clinic. His wife recently completed a fellowship in breast reconstruction at Sloan-Kettering.

**Timothy J. Michals**, 7008 Greenhill Rd., Philadelphia, has been appointed to a three year term as a member of the Board of Directors of Family Service of Philadelphia. Dr. Michals, a Clinical Assistant Professor of Psychiatry at Jefferson, also serves on the Boards of Albert Einstein Medical Center, Traveler's Aid Society and the Committee of Seventy. He presently is serving as President of the Medical staff at Einstein's Darrow Division.

## 1967

**Jane Mikuliak Breck**, 415 Devonshire St., Pittsburgh, has been enjoying pediatric practice in Pittsburgh for the last 17 years. Dr. Breck became consulting pediatrician to the Western Pennsylvania School for Blind Children in 1979, is the Director of the PKU (Pheunylketonuria) Clinic at Children's Hospital of Pittsburgh, and has been invited to represent Pennsylvania physicians in a People-to-People in China in early 1981.

**Carl L. Stanitski**, 224 Virginia Ave., Pittsburgh, has just been appointed Associate Clinical Professor of Orthopaedics at the University of Pittsburgh Medical Center. Dr. Stanitski had a superb sabbatical last year as a Fellow at Harvard at the Children's Hospital Medical Center in Boston. He has also enjoyed running in the Boston Marathon the past two years.



## 1968

**William J. Dennis**, 3823 J St., Philadelphia, has been appointed Director of the Pediatrics Department of Frankford Hospital.

**Carl D. Metzger**, 1123 Shore Rd., Cape Elizabeth, Me., is in the private practice of child, adolescent, and adult psychiatry. Dr. Metzger and his wife have four children.

## 1969

**Harold R. Hansen**, has been appointed to the Keene Clinic Medical Staff in the department of orthopaedic surgery in Keene, New Hampshire.

**Jesse H. Wright**, 2307 Thornhill Rd., Louisville, Ky., is Associate Professor in the Department of Psychiatry and Behavioral Science of the University of Louisville School of Medicine and Clinical Director of the Norton Psychiatric Clinic. He was given the "Golden Apple Award" for outstanding teaching by the Class of 1980 at the medical school.

## 1970

**William D. Bloomer**, 166 Hampshire Rd., Wellesley Hills, Ma., has been promoted to Associate Professor of Radiation Therapy at the Joint Center for Radiation Therapy and Harvard Medical School. He also serves on the staffs at the New Brigham and Women's Hospital and the Harvard-MIT Division of Health Sciences and Technology.

**John F. Dmochowski**, 25 Place Rd., Falmouth, Ma., is practicing general psychiatry in his home on Cape Cod.

**Allan P. Freedman**, 7821 Park Ave., Philadelphia, an Assistant Professor of Medicine at Hahnemann Medical College, has received a grant from the Council for Tobacco Research to study the effect of cigarette smoking on the alveolar clearance rate of pulmonary particulates. He also is the recipient of a grant from the U.S. Steel Foundation for research into the magnetic detection of occupationally acquired lung dust. Dr. Freedman also is an attending physician at Jeanes and American Oncologic hospitals. His wife, Barbara, is practicing tax law in Philadelphia.

**Steven A. Klein**, 33 Shepard Ln., Roslyn Heights, N.Y., is an obstetrician gynecologist at Nassau Hospital in Mineola. He is teaching, doing research and providing clinical care and finds the work stimulating as Director of Perinatal services. This coming year a 20 million dollar wing for maternal and child care will be completed. Dr. Klein's family, Daniela, Barak and Alexa, are well.

**James R. LaMorgese**, 4171 Oak Valley Dr., Cedar Rapids, Ia., was certified in neurological surgery in January, 1980.

**Lawrence S. Miller**, 145 South Burlingame Ave., Los Angeles, and his wife, Anita, are proud to announce the birth of their fourth child, Elisa Lynn, on October 17.

**John M. Shovlin**, 55 Laurel St., Carbondale, Pa., who is serving as the Medical Director of the North East Tri-County Medical Center, has been certified by the American Board of Psychiatry and Neurology in the specialty of psychiatry.

## 1971

**David R. Cooper**, 333 Stanley Dr., Kingston, Pa., has been appointed Chief of Orthopaedic Surgery at Geisinger-Wilkes-Barre. Dr. Cooper is currently organizing the orthopaedic department of the new NPW Regional Medical Center which will open in March of 1981.

**Steven W. Klinman**, 7908-B Bustleton Ave., Philadelphia, has been appointed to the faculty of Hahnemann Medical College as Clinical Assistant Professor of Medicine. He is an avid runner and recently completed the New York City Marathon, his first, in three hours and eight minutes.

**Edward B. Ruby**, 1133 Laurel Ln., Huntingdon Valley, Pa., was inducted as a Fellow of the American College of Physicians at the College's National Meeting held in New Orleans. He was also elected into the Endocrine Society. He is Director of Endocrinology and Metabolism at the Mercy Catholic Medical Center and is Assistant Professor of Medicine at Jefferson.

**Floyd F. Spechler**, 137 Cooper Ave., Cherry Hill, N.J., has opened a second office there for the practice of ophthalmology.

## 1972

**Stephen P. Flynn**, 3519-221 Ave. SE, Issaquah, Wa., and his wife had their first daughter, Kathryn Ann, on December 24, 1979.

**Philip C. Hoffman**, 1450 E. 56th St., Chicago, has been appointed an Assistant Professor of Medicine in the section of hematology/oncology at the University of Chicago.

**Joseph and Rosemary Horstmann**, 834 N. Ott St., Allentown, Pa., have moved to Allentown after completing their residencies in Minneapolis.

**Stanley R. Jacobs**, 1741 Marilyn Dr., Haver-town, Pa., and his wife, Judy, are happy to announce the birth of their son, Joshua, on April 8.

**James W. Redka**, 820 Louisa St. Williamsport, Pa., who practices family medicine

there, has added their third child, Matthew, age 6 from Korea, to the family.

**James R. Roberts**, 1525 Calle del Ranchero, Albuquerque, N.M., has been appointed Medical Director of the University of New Mexico Emergency Medical Services Academy. He has also been named by the US Department of Health and Human Services as a Consultant to review training grant applications. Dr. Roberts also is an Assistant Professor of Emergency Medicine at the University of New Mexico School of Medicine.

**James R. Roberts**, 1525 Calle del Ranchero NE, Albuquerque, N.M., is presently an Assistant Professor of Emergency Medicine at the University of New Mexico School of Medicine.

**Anthony R. Rooklin**, 70 Chapel Hill Rd., Media, Pa., and his wife had a son, David William, born June 21. Dr. Rooklin was appointed Assistant Professor of Pediatrics at Jefferson Medical College and is Director of the Division of Allergy and Immunology at Crozer-Chester Medical Center.

**Marshall A. Salkin**, 328 W. 2nd St., Claremont, Ca., and his wife had a daughter, Lauren Joy, on October 28.

**Cheryl R. Zaret**, Michigan Terr., 535 N. Michigan Ave., Chicago, announces the relocation of her office for the practice of neuro-ophthalmology and ophthalmology to the Garland Building, 111 North Wabash Avenue, Chicago.

## 1973

**Joseph A. Jacobs**, 417 Maplewood Ave., Merion Station, Pa., has been appointed Assistant Professor in the Jefferson Medical College Department of Urology.

**Frederick L. Kramer**, 7 Worthington Dr., Media, Pa., happily announces the birth of a second child, Brent Adam, July 13.

**Paul D. Manganiello**, 40 Village Green, West Lebanon, N.H., writes, "We are settled into New England living! It is beautiful country." He is on the staff of Mary Hitchcock Memorial Hospital and Clinic as their reproductive endocrinologist. The Manganiellos have a son, Marc, who was two in December.

**Russell E. Perry**, 100 Esther Ave., New Smyrna Beach, Fl., announces the birth of a third son, Brian Douglas.

**Joseph W. Sassani** has been appointed Assistant Professor of Surgery in the Division of Ophthalmology and Assistant Professor of Pathology at the Milton S. Hershey Medical Center. Dr. Sassani, following his internship and residency at the Hospital of the University of Pennsylvania, was a Fellow in ophthalmic pathology at the Scheie Eye Institute there.

# 1974

**Alice A. Angelo**, 109 Regency Park Rd., Agawam, Ma., recently opened an office for the practice of endocrinology and diabetes.

**David A. Brent**, 6551 Northumberland St., Pittsburgh, is engaged to Nancy Beranbaum, M.D., a resident in pediatrics at Children's Hospital in Pittsburgh.

**William J. Gibbons**, 428 Dogwood Dr., Southampton, Pa. announces the birth of the Gibbons first child, Lisa, in April 1980.

**Edward M. Jeryan** and his wife, Robin, have moved to Delray Beach, Florida. Dr. Jeryan is working at the Medical Treatment Center in Palm Beach Gardens where his practice is primarily family medicine and minor emergency care. Their residence is 3904 C. Spanish Wells Drive.

**John J. Karlavage**, 104 East Mahanoy Ave., Girardville, Pa., was recently appointed by Governor Thornburgh to the Governor's Council on Drug and Alcohol Abuse. Dr. Karlavage and his wife, Judy, are expecting their third child in March.

**James W. Kessel**, 1216 Virginia Ave., Charleston, W. Va., completed a Fellowship in July and has opened an office for the practice of surgery at the above address.

**Scott I. Lampert**, 71 Monet Ct., Atlanta, has entered the private practice of ophthalmology at 3280 Howell Mill Road there. Certified by the American Board of Ophthalmology in May 1980 he is limiting his practice to retina and vitreous work. The Lamperts had their first child, Samantha Morris, on October 6.

**John P. Lubicky** was appointed Assistant Professor of Orthopaedic Surgery at the State University of New York, Upstate Medical Center in Syracuse as of January 1. He is confining his practice to pediatric orthopaedics and spine surgery.

**Larry S. Mapow**, Clinical Laboratories, Millville Hospital, Millville, N.J., has been named Director of Laboratory Services at the hospital.

**Charles W. Maxin**, 611 University Dr., State College, Pa., has been appointed Instructor of Family Medicine at Jefferson.

**Jay S. Schinfeld**, 38 Lakewood Rd., Newton, Ma., is an Assistant Professor at Boston University Medical School. His specialty is gynecology, infertility and endocrinology.

**Edward J. Share**, 1464 S. Roxbury Dr., Los Angeles, is in the practice of gastroenterology and internal medicine in West Los Angeles and is teaching at Cedars Sinai Medical Center and the Wadsworth VA Hospital.

**Bruce B. Vanett**, 732 Hedgerow Dr., Broomall, Pa., has been certified by the American Board of Orthopaedic Surgery.

# 1975

**Angelo S. Agro**, 130 N. Haddon Ave., Haddonfield, N.J. has joined the Department of Surgery, otolaryngology section, of West Jersey Hospital.

**John H. Doherty, Jr.**, Box 458, RD #3, Clark's Summit, Pa., is associated with Drs. Samuel Todaro and **Gerald Gryczko '63** of Scranton for the practice of orthopaedic and hand surgery. He is also associated with Mercy Hospital, Community Medical Center, Moses Taylor Hospital, Scranton State General Hospital and Allied Services.

**Theodore A. Feinstein**, 1326 Spruce St., Philadelphia, has been appointed Instructor in Obstetrics and Gynecology at Jefferson.

**Richard D. Gordon**, 40 Fuld St., Trenton, N.J., has been appointed assistant to the Director of medical education at Helene Fuld Medical Center, there.

**John R. Hain**, 215 Richmond Ln., Pittsburgh, has been appointed Clinical Instructor in the Pathology Department of the University of Pittsburgh School of Medicine. He had a paper published in the July 1980 issue of *Obstetrics and Gynecology* and is a member of the American Society of Clinical Pathologists.

**Jonathan L. Kates**, 110 Highland Ave., Lansdale, Pa. has joined the orthopaedic staff at North Penn Hospital in Lansdale after completing his residency in Miami, Florida.

**Fred H. Miller**, 2000 Shore Rd., Linwood, N.J., has opened a practice in internal medicine in Linwood. He is on the staff of Shore Memorial Hospital and Atlantic City Medical Center.

**David H. Moore**, 236 Mackell Ave., Dallas, Pa., has been appointed an Associate in gastroenterology at the Geisinger Medical Group in Wilkes-Barre, Pennsylvania.

**Craig L. Muetterties**, 240 Rushley Way, Media, Pa., has been appointed Instructor of anesthesiology at Jefferson.

**Donald L. Myers**, 1500 Locust, Philadelphia, has been appointed Instructor of neurosurgery at Jefferson.

**Alexander G. Paterson**, Box 193, Laughlintown, Pa., was appointed Instructor of Medicine at Jefferson.

**Michael D. Perilstein**, 26 Ironstone Dr., Reading, Pa., has set up a practice in rheumatology at 1603 E. High St. in Pottstown. He is Board certified and a member of the American College of Physicians.

**Laurence R. Plumb**, 69 Crescent Ave., Buffalo, N.Y., has recently opened offices for the practice of family medicine and the treatment of minor emergencies. He is a faculty member of the family practice department at the University of Buffalo Medical School and a teacher in the family practice residency program at Deaconess Hospital.

**John T. Santarlas**, Box 104, RD #2, Derry, Pa., has been appointed Instructor of family medicine at Jefferson's affiliate, Latrobe Hospital.

**Lewis S. L. Sharps**, 300 W. Lancaster Ave., #806, Wynnewood, Pa., has completed his residency at Jefferson in orthopaedic and reconstructive surgery and is associated with Dr. Karl Rosenfeld of Phoenixville.

# 1976

**William S. Carter, III**, Maine Medical Center, Portland, Me., has been named to the staff of Webber Hospital. He will maintain an office at 234 Main St. in Biddeford.

**John R. Cohn**, 3602 Barcelona Ave., Durham, N.C., his wife Sherry, and daughter Joanna Beth, were joined last July by Benjamin Michael. Dr. Cohn is a Fellow in a combined program in allergy and immunology and pulmonary medicine at the Duke University Medical Center.

**Joanna Miller Connolly**, McGuire Cottage, Gravers Ln. & Flourtown Pike, Wyndmoor, Pa., has been appointed an Instructor of obstetrics and gynecology at Jefferson.

**Robert L. Goldberg**, 7030 Walnut Woods Dr., Modesto, Ca., was named plant physician for the Hershey Chocolate Company's western plant in Oakdale in April. He has gained a private pilot's license and is now working towards an instrument rating.

**Marc E. Gottlieb**, 1-E Downing Square, Guilderland, N.Y., is in the second year of a two year Fellowship in shock and trauma at the Albany Medical Center. He also is completing work on a master's degree in physiology. Following the completion of his general surgery training in 1983 he will begin training in plastic surgery.

**Kathleen A. Kucer**, 9 Tiffany Rd., Perkasio, Pa., has joined the staff of Grand View Hospital in Sellersville after completing a residency in dermatology at Jefferson.

**David W. Willis**, Box 165, Route 2, McMinnville, Or., has begun a private practice in pediatrics there with colleague Blaine E. Tolby. He completed his training at the University of Oregon Health Science Center where he was a resident for two years and a Fellow in child development and behavioral pediatrics for two years. He has passed his Boards for the American



# The Boat Lift

by Duncan Salmon, M.D. '78



Dennis O'Keefe, Philadelphia Daily News

In early May, as the Cuban boatlift became the dominant news item on nightly television, the call went out for bilingual physicians in the Public Health Service to assist in providing medical care for the refugees. Having spent time when younger in Mexico and Argentina, I had the necessary knowledge of Spanish and volunteered.

I was immediately sent to Miami for what was supposed to be a 72 hour stay. My wife, Beverly and our year-old son, Morgan, came along for a quasi-vacation. Little did I suspect that I would be spending three weeks in Florida, and that the few moments I had with my family would be spent sleeping off my exhaustion.

In Miami, I met my classmate Charles Stutzman, who had come down to help coordinate the Miami program. Chuck and I had interned together at the Baltimore United States Public Health Service Hospital before he completed his Master of Public Health degree at Johns Hopkins, and he and his

lovely wife, Roberta, had become close friends of ours. (Chuck is currently an Epidemiologic Intelligence Officer at the Center for Disease Control in Atlanta, and was recently in Damascus, Georgia to investigate the Titan missile explosion.)

The program was being hastily set up when I arrived. I worked in several huge armories filled with military cots from wall to wall, all occupied by newly arrived Cubans. In the beginning, there was a great shortage of medical supplies as the existing systems scrambled to respond to the emergency. I was confronted with infected bites from the Cuban guard dogs but no antibiotics or tetanus toxoid, broken arms but no X-ray facilities or cast plaster, insulin dependent diabetics who had been without insulin for days but no insulin or Dextrostix. After a few frantic telephone calls, basic supplies began to arrive. Still, I was forced to rely almost solely on clinical judgement in evaluating and treating my patients. I was happily surprised

to see how well I was able to handle the medical emergencies without reliance on blood tests, EKG's, textbooks or X-rays.

There were some minor problems with the private sector. The Cubans had not yet been given medicare status, and the hospitals were reluctant to fill their rooms with refugees whose treatment might not be reimbursed. The government agencies and volunteer teams were extremely dedicated and did an admirable job, however, and I was impressed with the massive outpouring of support from the Miami community.

My family and I stayed in Hollywood, north of Miami. I was often gone 20 hours a day; when I came home to sleep, the phone would often ring because of an emergency with one of the patients. Only the tremendous need and the Cuban coffee spurred me on and kept me going. My wife was having trouble with Morgan who was homesick, and had a hard time for the first five days. I was able by that time to or-

ganize local volunteer physicians to staff the armories and expected to be sent home. The Key West situation, however, was getting worse and we flew down there to help out. In Key West, I was able to work a 12-hour night shift and could therefore stay with my family during the daytime.

The boatlift was reaching a crescendo and near chaos threatened at the docks. I worked with other Public Health Service physicians, nurses and Marine Corpsmen and staffed the emergency triage clinic on the waterfront, located in the old Navy base Administration building. The Marines, flown in from South Carolina, were short-haired, rough-and-ready types. They showed remarkable understanding and compassion towards the refugees.

We saw over 500 people daily in the clinic, mostly suffering from dehydration, seasickness and anxiety. On many boats, over half of the refugees were young male prisoners who had been taken from their cells, given civilian clothes and false papers, and put on the boats. Many of them told stories of shocking brutality and bore the scars of bayonet tips and gun butts.

Several elderly refugees, dying of advanced cancer, had been taken from hospital beds and put on the boats because their families had left on the boatlift. One man arrived with a foley catheter still in his bladder, plugged with a glass ampule of furosemide; his bladder had over three litres of urine when the ampule was removed.

Young women repeatedly told of being raped by Russian soldiers as they waited in Mariel Harbor to board the boats; many of them had extensive hematomas on their hips and thighs from the beatings they received for resisting.

Virtually all of the Cubans who decided to leave were unhappy with the Cuban social system, which they felt no longer represented their needs and wishes. The finest beaches were reserved for vacationing Soviet bureaucrats. The best tobacco and coffee was sent to Europe, leaving the Cuban people with severe rationing and lingering resentment. In every aspect of life there was a remarkable loss of the most basic liberties. Those who left only wanted to make something of their lives and to reap the benefits of their labor.

The situation was summarized for me in the words of one Cuban: "When I

was young and Batista had just been overthrown, I thought, 'this is good; the poor who had no clothes now have clean clothes and good food.' But in the last years, one once again sees poor people without clothes, and I now realize we are no better off than before and probably worse."

We have a wonderful Cuban community in this country; without them to sponsor refugees and help to find jobs, the refugees would have had a much harder time. As a resident in the Public Health Service, I continue to care for Cuban refugees with tuberculosis and varied other medical problems. It is rewarding to see them learning our language and adapting to our way of life. Most of these people are hard working and honest and will be a valuable addition to our country.

Reflecting on the whole episode, I am appalled by Castro's actions in dumping his prisoners and, as he himself said, "the scum of Cuba," onto the boats. We received many emotional misfits, hardened criminals, and overtly psychotic persons. Some had been lashed, babbling, to the boat rails to keep them from jumping overboard. We, I feel, should have insisted on a more orderly exodus with proper screening and organized facilities. Unfortunately, however, we are now saddled with a small core of refugees who will continue to be a burden and a drain on our society for years to come.

In the three weeks I spent in Florida, I learned a great deal about the cruelties man can inflict on his fellow man. I gained confidence in my ability to handle any emergency with little more than my stethoscope and clinical skills. I got tremendous satisfaction from the help I was able to give these poor souls arriving in a strange land with only the clothes on their backs. Meaningful little things happened all day long, every day. The patients were wonderfully appreciative. When I had successfully treated a mother's dehydrated baby or an elderly woman's severe seasickness, I was extremely moved by the immense gratitude of people who had experienced so much indifference.

As we left Florida, memories of the volunteers, the Marines, and the thankful faces of the refugees flooded back to me. I was filled with pride for the compassion we showed and the warm welcome with which we received these destitute people.

Academy of Pediatrics. Dr. Willis and his wife, the former Margaret A. Fratto, had their first child in October.

**Robert S. Zibelman** announces the opening of his office for the practice of adult and child psychiatry at the Benson East in Jenkintown, Pennsylvania.

## 1977

**Carl A. Barbee**, P.O. Box 509, Hailey, Id., has completed a three year residency in family practice at the Wilmington Medical Center in Delaware and has joined three other family physicians in Hailey just 12 miles south of Sun Valley. "Have plenty of room for friends in class or Phi Alpha. Come enjoy one of the best skiing mountains in the world."

**Geoffrey R. Burbridge**, 6328 Longwood Dr., Erie, Pa., has joined the staff of Hamot Medical Center as a general internist.

**John A. Ferriss, III**, 24 Laurel Point Dr., Oakdale, Ct. is engaged to Mary E. Maloney, M.D. of Lyme, New Hampshire. He is a lieutenant in the U.S. Navy Medical Corps, stationed in New London.

**Jan S. Glowacki**, 561 River Rd., Fair Haven, N.J., has opened an office for the practice of internal medicine in Fair Haven. He recently received the John C. Borden Internal Medicine Award for distinguished performance in medicine.

**Albert D. Janerich**, Bullford Rd., RD/5, Shavertown, Pa., has been appointed Director of rehabilitation medicine with the Geisinger Medical Group in Wilkes-Barre, Pennsylvania.

**Samuel M. Lesko**, 10 Biltmore Rd., Huntington, Ct., has been appointed to the staff of the Family Health Care Center in Shelton, Connecticut. He is a member of the Connecticut Academy of Family Practice and the American Academy of Family Physicians.

**Warren B. Matthews**, 2826 Mount Carmel Ave., North Hills, Pa., completed his residency in Family Practice at Abington Memorial Hospital in June and was certified by the American Board of Family Practice in October. He is currently in private practice in North Hills and on the staff of both Abington Memorial and Chestnut Hill Hospitals. In addition, Dr. Matthews is a Clinical Instructor in Family Practice at the Montgomery Hospital residency program in Norristown, Pennsylvania.

**William J. Steinberg**, 1212 Hawthorne Ln., Fort Washington, Pa., was named Director of the Emergency Unit at the Albert Einstein Medical Center, Northern Division.

**Michael G. Weinberg**, 326 Spring St., Latrobe, Pa., has joined the staff of Latrobe



Area Hospital and entered family practice with **William M. Weisel '76**. Dr. Weinberg and his wife, Susan, have a three year old son, Gary.

## 1978

**Harry L. Chaikin**, Media Station Rd., Media, Pa., was honored by the Wilmington Medical Center with the award for the best research paper for 1979-1980. The paper, titled "Rhabdomyolysis Secondary to Drug Overdose and Prolonged Coma", was also published in the August 1980 edition of *Southern Medical Journal*. Dr. Chaikin coauthored a second paper titled "Bone Scan in Rhabdomyolysis" published in July 1980 *Clinical Nuclear Medicine*.

**Donald B. Parks**, 4645 S. Morris St., Philadelphia, and his classmate **Ronald Andrews** are founders of the Charles Drew Award Committee at Amherst College, to honor the memory of Dr. Drew. The Award aids minority medical students.

**Neil H. Shusterman**, 2315 Kenilworth Rd., Ardmore, Pa., and his wife Cheryl, had a son, Matthew Haim, on April 14. Dr. Shusterman is finishing an internal medicine residency at Lankenau Hospital and will begin a renal Fellowship at the University of Pennsylvania Medical School in July.

## 1979

**Richard T. Fields**, 6324 NW Taylor, Lawton, Ok., married Karen A. Stemetzki in August. The couple then moved to Oklahoma where he is serving as a surgical resident in the U.S. Indian Public Health Service.

**Bernadette C. Genz-Remshard**, 114 Parkview Rd., Cheltenham, Pa., and her husband, John, announce the birth of their first child, John Bernard, on August 14.

**Patricia M. McGuire**, who presently is a psychiatric resident at Jefferson, won the women's division of the University sponsored Lite Ten Mile race last fall in 1:17:40. The race began at Jefferson Alumni Hall, continued to the East River Drive, back on the West Drive and onto campus.

## 1980

**William E. McLemore** will begin a residency in radiology at Ohio State Medical Center this summer.

**James P. Rupp**, 25102 Delaire Landing Rd., Philadelphia, married Theresa M. McGlynn in June.

**Randy R. Westgate**, 113 Moorwood Rd., Glenshaw, Pa., received the Philadelphia Academy of Family Physicians Memorial Award for "demonstrated excellence and interest in the specialty of family medicine."

# Obituaries

## Theodore C. Zeller, 1923

Died October 18, 1980 at the age of 82. Dr. Zeller, who was in Macon, Georgia, at the time of his death, was an eye, ear, nose and throat specialist with a practice in McKeesport, Pennsylvania. A member of the McKeesport Hospital he was a past President of the Rotary Club there.

## Aaron Capper, 1924

Died January 24, 1980 at the age of 83. The retired physician was a resident of Beverly Hills, California at the time of his death. A member of the American Academy of Pediatrics Dr. Capper served as an Associate Professor at Jefferson. He was Senior Attending at Jewish Hospital in Philadelphia. Surviving are his wife, Estelle, and two sons, **Stanley A. Capper '51** and **Robert Capper '55**.

## Samuel G. Scott, 1924

Died July 7, 1980 at the age of 95. The general practitioner was a resident of Jersey City, New Jersey.

## Carl O. Lungerhasuer, 1928

Died July 1, 1979 at the age of 76. Dr. Lungerhauser was a general practitioner who resided in Sebring, Florida. His wife survives him.

## Alberto Oreamuno Flores, 1929

Died October 27, 1980 at the age of 75. Dr. Oreamuno, a general surgeon, was one of Costa Rica's most prominent political and cultural leaders. During his career he served as First Vice President of the Republic and sought the nomination of the National Union party. He was a founder of the United States Cultural Center. Surviving are his wife, Betty, and two sons. His brother in law is **Frederick A. Robinson, '41**.

## William R. Stecher, 1929

Died September 20, 1980 at the age of 74. Dr. Stecher, a radiologist, had recently moved to Sun City Center in Florida. During his professional career he was Chief of Radiology at Prince George's General Hospital in Silver Springs, Maryland, and serves as Associ-

## James A. Gettings, 1916

Died September 6, 1979 at the age of 88. Dr. Gettings was Attending Surgeon and President of the Staff at St. Raphael's Hospital in New Haven, Connecticut where he practiced from 1925. He also served as President of the New Haven Medical Association and the New Haven County Medical Society. A Fellow of the American College of Surgeons Dr. Gettings was awarded the Charles Carroll of Carrollton Medal given by the Knights of Columbus.

## John W. Green, 1916

Died October 19, 1979. Dr. Green, a retired physician, was a resident of San Antonio, Texas, and had been associated with the State Hospital there.

## George A. F. Lundberg, 1919

Died May 13, 1980. Dr. Lundberg, a retired physician, was a resident of Manchester, Connecticut. In 1971 he was named an Honorary Director of the Heart Association of Greater Hartford. Through membership in Jefferson's President Club Dr. Lundberg established the Lundberg Memorial Scholarship Fund. Surviving is his son **George A. F. Lundberg, '53**.

ate Professor at Georgetown University Medical School. An author of many articles Dr. Stecher was a member of the American College of Radiology and the American Board of Radiology. Surviving are his wife, Erna, a son, **William A. Stecher '58**, and a daughter.

**Harry Williams, 1929**

Died September 2, 1980 at the age of 77. Dr. Williams was a general practitioner who resided in Elkland, Pennsylvania for nearly 50 years. The Business Men's Association there has established the Dr. Harry Williams Scholarship Fund in his memory. Surviving is his widow, Lorensa.

**James S. Jordan, 1930**

Died October 12, 1980 at the age of 77. Dr. Jordan, an ophthalmologist in Scranton, Pennsylvania, was Chief of Surgery at Mercy Hospital there. A Director of the Lackawanna County Association for the Blind he was a member of the American Academy of Ophthalmology and a Fellow of the American Board of Ophthalmology. He was the recipient of numerous awards for recognition of excellence in his specialty. Dr. Jordan, a prominent Catholic layman, served as President and Trustee of Marywood College. He was elevated to Knight Commander with Cross in 1963 and later was invested in the Knights of Malta. He is survived by his wife, Mae, a daughter, and four sons, three of whom were in practice with him including **Jerome W. Jordan '71**.

**Charles L. Ball, Jr., 1931**

Died May 27, 1980. Dr. Ball was a general practitioner with a residence in Linthicum Heights, Maryland. Surviving is his wife, Sue.

**William L. Hughes, 1932**

Died August 16, 1980. Dr. Hughes, a resident of Johnstown, Pennsylvania, served as Medical Director of the American Red Cross Johnstown Regional Blood Center which covered 40 hospitals in three states.

**Samuel R. Kaufman, 1932**

Died October 19, 1980. Dr. Kaufman, a

dermatologist, resided in Wilkes Barre, Pennsylvania.

**Herman F. Meckstroth, 1932**

Died September 21, 1980 at the age of 73. Dr. Meckstroth had served as Medical Director of the Elizabethtown Masonic Home for 14 years prior to his retirement in 1977. He resided in Maungie, Pennsylvania.

**Irwin L. Kaufman, 1935**

Died June 24, 1980 at the age of 69. Dr. Kaufman, a general practitioner, was associated with Montefiore and St. Clair Memorial Hospitals in Pittsburgh, Pennsylvania.

**Henry Lihn, 1938**

Died July 21, 1980. Dr. Lihn was a psychiatrist who resided in Beverly Hills, California.

**Morris Parmet, 1939**

Died November 22, 1980 at the age of 67. Dr. Parmet, a child and adolescent psychiatrist in the Princeton, New Jersey area, served as Associate Clinical Professor at Rutgers Medical School and Consultant to the Princeton Medical Center and Carrier Clinic. He was President and Professional Advisor to the New Jersey State Mental Health Association and a Fellow of the American Academy of Child Psychiatry, the American Psychiatric Association and the American Orthopsychiatry. Surviving are his wife, Belle, and two children.

**Agustin M. deAndino, 1944S**

Died November 14, 1980 at the age of 59. Dr. deAndino, a resident of Puerto Rico, was a Fellow of the American College of Physicians. A member of the faculty of the University of Puerto Rico Medical School he was a founder and President of the Puerto Rican Endocrine and Diabetic Society. He was active in the Casa Nacional de la Cultura. Surviving are his wife, Diva, and four children one of whom is **Richard M. deAndino '76**.

**F. O'Neil Robertson, Jr., 1944S**

Died September 2, 1980 at the age of 62. Dr. Robertson had practiced general medicine in Ford City and Kittanning,

Pennsylvania. Recently he was Director of the emergency room at Armstrong County Memorial Hospital.

**James U. Oliver, 1947**

Died March 29, 1980. Dr. Oliver, an obstetrician/gynecologist, resided in Raleigh, North Carolina. Surviving are his wife, Lucille, and three children.

**John M. Kohl, 1948**

Died October 4, 1980 at the age of 56. Dr. Kohl, a resident of Wayne, Pennsylvania, was Chief of the Department of Radiology at Montgomery Hospital in Norristown. He is survived by his wife, Doris, four daughters and two sons.

**Northern L. Powers Jr., 1949**

Died March 27, 1980 at the age of 54. A general surgeon Dr. Powers resided in Pasadena, Texas.

**Stanley Weinstein, 1949**

Died September 29, 1980 at the age of 58. Dr. Weinstein, who practiced internal medicine in the Philadelphia area, was a member of the American Society for Internal Medicine. Surviving are his wife, Janet and three sons.

**Joseph S. Matta, 1950**

Died October 7, 1980 at the age of 65. Dr. Matta was a general practitioner with offices in Drexel Hill, Pennsylvania. Surviving are his wife, Helen, and two sons.

**James S. Koury, Jr., 1953**

Died November 13, 1980 while playing racquet ball. A resident of Harrisburg, Pennsylvania, Dr. Koury had maintained a general medical practice in that area for 20 years. Surviving are his wife, Audrey, four daughters and a son.

**Roger D. Lovelace, 1953**

Died September 25, 1980 after a long illness. Dr. Lovelace was a general practitioner who resided in Pitman, New Jersey. In addition to his private practice Dr. Lovelace served as the Gloucester County Medical Examiner and was the local school physician. He served as President of the Gloucester County Medical Society. His wife survives him.



Concern is expressed in the report about the influence of early specialization on the perspective of medicine, the need for more generalism in the early phases of medical education, and in the organization of medical schools themselves. Jefferson has done much to stress the general medical disciplines in our current curriculum and, indeed, this was the purpose for constituting a Department of Family Medicine and for strengthening general internal medicine and general pediatrics as part of our faculty structure. As a result, there has been a considerable change in the career plans of our graduates toward areas of more general patient care.

Jefferson has been one of the few American medical schools to maintain a balance between education by full-time faculty and by volunteer faculty, and also education at the university hospital and in community hospitals. This new report stresses the benefits to the student and to the community of this kind of balance. It points out how important it is for medical students to experience teaching and medical practice in a community hospital so that the student and also the full-time faculty which is university based can be kept abreast of the needs and problems of the practicing profession.

The past 15 years has been a period in which the social responsibilities of medicine have been pressed upon our medical schools by government and by various agencies and organizations to an extent that the independence, self-determination and resources of our schools have been threatened. Recognizing that the medical schools do have social responsibilities, the report points out very appropriately that our primary responsibilities are still education and research and these are not to be overtaken by other causes. This is a timely warning for Jefferson and for all of higher education. While we have made efforts to be more involved in social and community affairs in recent years and have devoted a lot of our time and resources to such projects as the Community Mental Health Program, the Children and Youth Program, Jefferson Health Care, Inc., the South Philadelphia High School Program and others, it has become evident that sometimes other agencies are more suited to administering such programs than an academic health center.

Finally, this report refers to the evaluation of medical student accomplishments, and especially the development of their capabilities in noncognitive matters. Our student promotions committee and the professorial faculty have given considerable attention to this matter in recent years, and while we recognize that our size imposes an additional difficulty on our faculty in these areas, we also know that the magnitude of our problem does not excuse our responsibilities to develop more effective assessment procedures to judge a student's development in behavioral and interpersonal matters. Currently the student promotions committee is trying to devise new methods for measuring a student's development in these areas.

A comparison of our educational activities at Jefferson with the recommendations of this report which pertain to undergraduate medical education suggests that our faculty has been alert to the issues of the time and has been making appropriate efforts to alter our programs and our functions to respond to them.

### **An Invitation to Alumni**

**to present names of candidates for**

### **The Alumni Achievement Award**

Jefferson's most prestigious award will be presented at the Alumni Banquet on June 4, 1981. The award is given annually by the Association to an alumnus who has distinguished herself/himself in the field of medicine. Nominations with supporting information should be forwarded to James H. Lee, Jr., M.D. Chairman, Achievement Award Committee, Alumni Office, 1020 Locust Street, Philadelphia.

## ALUMNI CALENDAR

### January 30

Dinner at the Wilmington Country Club  
for Delaware alumni and faculty

### February 7

Reception for alumni in conjunction with  
the opening of the Birmingham Art Mu-  
seum's exhibition "Medicine and Science in  
American Art" at the Museum. "The Gross  
Clinic" will be on loan.

### February 7-14

Caribbean Cruise, the 19th Post-graduate  
Seminar

### February 26

The Annual Business Meeting and Dinner  
of the Alumni Association  
Penn Mutual Towers

### February 28

Reception in conjunction with the meetings  
of the American Academy of Orthopaedic  
Surgeons, the Las Vegas Hilton

### March 20

Parents' Day for sophomore students,  
Jefferson Medical College

### April 7

Reception in conjunction with the meetings  
of the American College of Physicians,  
Hyatt House, Kansas City

### April 25

Black and Blue Ball  
Bellevue Stratford Hotel

### April 27

Reception in conjunction with the meetings  
of the American College of Obstetricians  
and Gynecologists, Las Vegas Hilton

### May 11

Reception in conjunction with the meetings  
of the American Psychiatric Association  
The Royal Orleans, New Orleans

### May 16

Reception in conjunction with the meetings  
of the Medical Society of New Jersey  
Meadowlands Hilton Secaucus

### June 3, 4 and 6

Reunion activities

### June 5

Commencement  
The Academy of Music

## REUNIONS, 1981

Clinics, Dean's Luncheon,  
Class Parties **June 3**

Alumni Banquet, Franklin  
Plaza Hotel **June 4**

### 1931

Dinner  
Jefferson Alumni Hall

### 1936

Dinner  
The Cosmopolitan Club

### 1941

Dinner  
The Union League of Philadelphia

### 1946

Dinner Dance  
The Philadelphia Club

### 1951

Dinner  
Place to be announced

### 1956

Dinner Dance  
The Historical Society  
of Pennsylvania

### 1961

Dinner  
Le Bistro, Society Hill

### 1966

Dinner  
Penn Mutual Towers  
Saturday, June 6

### 1971

Dinner Dance  
Jefferson Alumni Hall  
Saturday, June 6

### 1976

Dinner Dance  
Jefferson Alumni Hall  
Saturday, June 6

### 1980

Cocktail Party  
Jefferson Alumni Hall  
Saturday, June 6



